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THE CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

SANTA FE, NM

SEPTEMBER 3, 1986

Serial No. 99-27

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THE CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS

WEDNESDAY, SEPTEMBER 3, 1986

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Santa Fe, NM.

The committee convened, pursuant to notice, at 10 a.m., at the PERA Building, Apodaca Hall, Hon. Jeff Bingaman presiding.

Present: Senator Jeff Bingaman and Congressman William B. Richardson.

Staff present: Faith Roessel, legislative assistant; William Benson, minority professional staff; Consuelo Trujillo, legislative intern; Rebecca Bustamante; Delores Garcia; and Scott Alley.

OPENING STATEMENT BY SENATOR JEFF BINGAMAN, PRESIDING

Senator BINGAMAN. I think we should go ahead and get this hearing started if everyone is ready.

Let me start out by saying that it's a pleasure to be here in Santa Fe to chair this hearing on the health care needs of the Indian elderly. I want to thank all of you for being here today and thank the witnesses who have come to testify on this important subject. This is an official hearing of the Senate Special Committee on Aging, of which I am a member. I want to first of all thank Senator Heinz, who is the chairman of the committee, for allowing us to hold the hearing and also thank Senator Glenn, who is the ranking Democratic member. Our hearing today completes the series of hearings that the committee has held on the quality of health care issues facing elderly Americans today.

Before I get into a description of the hearing, I want to make a few introductions. I will start by mentioning the people on my staff who have done the work in putting this hearing together, and particularly also the staff of the Special Committee on Aging. Faith Roessel, who is here with me today, has played a key role in organizing this and getting people involved. And with her is Consuelo Trujillo, who is an intern working with us. Consuelo and Faith have done all the leg work to get this thing done. Helping them has been Becky Bustamante, who you all know is here in our Santa Fe office. Delores Garcia, who is here in our Santa Fe office. Scott Alley who is in our Albuquerque office but has helped with the press part of this activity. We appreciate particularly Bill Benson, who is here today from the Special Committee on Aging to help us with this hearing as well. He's done a lot of work, and we appreciate his presence.

Let me make two other introductions. There are probably a lot of people in the audience that I should introduce, and I will introduce the witnesses as we go along. I'm particularly pleased to note that today Wendell Chino, who is the president of the Mescalero Tribe, is here today. Where is Wendell? Wendell, thank you very much for being here. We appreciate it.

And Gilbert Pena, who is the chairman of the All Indian Pueblo Council, is here. We appreciate you being here.

Mr. PENA. Good morning, Senator, and welcome to Santa Fe.

Senator BINGAMAN. We're glad to be here. Let me go ahead and discuss the purpose of the hearing for just a couple of minutes, and then we will start with our panels and get our witnesses up here.

The purpose of this hearing is to examine the State, Federal, and tribal resources available to Indian seniors in the context of health care services. And the jargon which is used in the health care field, I found out, is termed the "continuum" of health care services. That's the word that's used. "Continuum" sounds like a fancy word. What we're talking about is trying to have a coordinated system of health care and social services to meet the health care and related needs of Indian seniors. Ideally this system needs to begin, of course, with health promotion and disease prevention efforts. It must also include essential social services, such as transportation and nutritional sites. This system should have home health care and finally it should include intensive long-term care services, such as nursing home care.

The system must prevent unnecessary deterioration of an individual's health condition as they grow older. It must help postpone inevitable decline and in the most appropriate way possible, deal with the individual's health care needs. Such a system needs to be accessible. It needs to be affordable. It needs to be culturally sensitive and realistically suited to the needs of Indian elders. And it needs to focus on ensuring independence of the people who are served and not increasing the dependence of those people on the system. As the testimony will indicate, we have a great deal to do to create such a system.

Quite understandably when we talk about the problems of the Indian community, we tend to focus on the young because the Indian community is predominantly young. But I believe now is the time to begin improving and coordinating our resources to deal with the elderly, the needy, in the Indian community, so that those problems don't overwhelm us in the days and years ahead. Just as in our society at large, there is a demographic explosion in the Indian community which is rapidly increasing the number of Indian seniors who will need the type of services we will be discussing.

In order to understand how to put together a coordinated health care system, we need to hear from the people, first of all, who are directly effected.

Today we have some outstanding witnesses. I want to take a few minutes to describe the overall hearing and the panels we're going to have.

Our first witness is going to give us a national perspective. This witness is Curtis Cook, who is the executive director of the National Indian Council on Aging located in Albuquerque. He is going to provide us with that overall national view. I understand that next week NICOA is going to hold its National Indian Aging Conference. I hope the testimony we develop here will complement the discussions that will take place at that national conference. The hearing record that we're making today will be open for at least the next 3 weeks, so that conference participants who wish to make recommendations and put information into our hearing record can do so.

Our first panel after Mr. Cook is composed of tribal and senior representatives who are going to describe the tribal viewpoint on these issues. The Eight Northern Pueblos, the Sandia Pueblo, the Navajo Tribe, the Jicarilla Apache Tribe, and the Mescalero Apache Tribe have all sent spokespersons to be here today and to describe their point of view on these important set of issues.

The next panel after that will be service providers beginning with a medical doctor, a title VI program director, and a home health care provider. Also to round out the panel we will hear from those directly involved in the delivery of long-term health care, and here we have in mind the Laguna Pueblo's nursing home and the Navajo Tribe's nursing home, which are both represented.

The State and Federal perspective is also going to be shared with us. We have a full panel, with representatives from the U.S. Department of Health and Human Services, the Bureau of Indian Affairs, ACTION, the U.S. Department of Agriculture, and the Department of Housing and Urban Development. They're all present to describe the various Federal programs and to address the issues of delivery of services and coordination of those services. To present the State view, the State Department of Health and Environment and the State Department of Human Services are represented through the Office of Indian Affairs. We will also hear from the State Agency on Aging as well.

Finally the last panel will discuss the future in some general way. We've called that panel "Taking Charge," and we have two excellent witnesses. Larry Curley, who is a consultant on Indian elderly issues, will make some recommendations and observations, and Paul Nathanson, who is the director of the Institute of Public Law at the University of New Mexico Law School, will put some of these concerns in a national perspective. He will focus his remarks on how Indian elderly health care issues fit into the broader framework of national elderly health care issues.

I think this will be an informative hearing. As you can see we have an extensive list of witnesses. I've asked and I believe that each of the witnesses have been advised that we would like them very much to try to keep their oral remarks to about 5 minutes, so that we can have a chance for questions and discussion. All the written testimony will be printed in the record in full, and copies of that will be made available to people so we do not need to have a word for word recitation of the written testimony.

The video that was shown before the hearing today was developed as part of an intergenerational cardiovascular fitness project out of UNM's Medical School. It involves the Laguna, Acoma and Navajo Tribes. We will try to show this video again during the luncheon break, and we will also show it right after the hearing for anybody who is interested in viewing it. I encourage all of you to view it if you do have time.

The schedule today is to go until noon, to then break for about 45 minutes so people can get some lunch. And then to start up again before 1 o'clock and go until 3 o'clock. So that's our hearing schedule. We hope we can keep pretty close to that. I believe that Congressman Richardson will be here for part of the hearing this morning. Of course, when he arrives, I would like to interrupt whoever is testifying and give him a chance to make any statement he wants to; and, of course, to the extent that he can stay and ask questions, that would be all the better.

So let me just go ahead and start by calling the first witness, and if Mr. Cook would come forward and give his testimony. Then I might have a question or two, then we will go to the first panel after that.

Thank you very much for being here.

STATEMENT OF CURTIS COOK, ALBUQUERQUE, NM, EXECUTIVE DIRECTOR, NATIONAL INDIAN COUNCIL ON AGING

Mr. Cook. Thank you, Senator Bingaman. I appreciate it very much. I want to say on behalf of the National Indian Council on Aging and the 109,000 or more Indian elders that we serve, we appreciate very much your efforts on our behalf. In all my contacts across the country, from coast-to-coast and throughout the State of New Mexico working with the tribes, I have repeated you are one of our best friends in high places. And we certainly need your help. We want to thank you very sincerely for all that you are doing on our behalf.

I first became acquainted with the Indian elderly issues 22 years ago. And I've been in that business since that time. Then 22 years ago I moved to an Indian pueblo in northwestern New Mexico, took up residence with an elderly Indian family and learned many things about the life of elderly persons. In all of that 22 years, my life has been greatly influenced by my contact, my association with Indian people. But in particular with the Indian elders.

I've been asked to give an overview from the national perspective of the health concerns and issues effecting Indian elderly in our country today. Much of what I have to say is documented in my written testimony, and so I won't spend much time referring to that.

I would simply like to say in general that the Indian elderly people of our country live in almost incredibly improverished conditions. They live in poor housing. They live in areas where there is high unemployment. They live in the midst of fragmented and gap filled health care services. The prospect for the Indian elderly is not good in these days of decreased budgets and increasing elderly population. The resources to go around are simply not enough to meet the need at the present time. Let alone what will occur in the future.

We are told that projections say the Indian elderly population will be more than 200,000 people by the year 1990. We're only 3½ years away from that. We're lagging far behind in services designed to meet the need. Those of us who know the situations on the reservation and in urban areas also know there is no continuum of health care for the Indian elderly.

Because a continuum implies a system and implies coordination. One of our major problems is the lack of coordination and the many gaps in services. I think you will agree that most of us who are not Indian people or nonreservation residents have had a opportunity to have the right kinds of health care throughout our lives. For the Indian elderly this is not so.

The studies conducted by the National Indian Council on Aging over the past 6 years has successfully documented the fact that the Indian elderly live in poor housing, live in poor health and are in great jeopardy in their daily lives. Dr. Spiro Manson and Dr. Donald Calloway in a recent article on Health and Aging among American Indians have summarized the situation by saying the majority of reports suggest that several morbidities, pneumonia, diabetes, alcoholism and dental health and arthritis are especially devastating to the elderly Indian populations. Further they state growing older represents great difficulties for a sizable segment, perhaps 30 percent of the aged population. Being Indian and being old intensifies the difficulties. But being an Indian over age 75 and living in a rural area may represent being a member of the most discriminated segment of American society.

Indeed, a recent study cited by the Senate Special Committee on Aging indicates that mortality rates among Indian people are considerably higher than the national U.S. population rates; 4½ times higher in alcoholism; 2½ times higher in tuberculosis; 1½ times higher from accidents; 107 percent higher from diabetes; and 66 percent higher from pneumonia. Life expectancy of Indian people around the country reported by the U.S. Census Bureau is 8 years less than the general population.

Another recent NICOA survey found that 71 percent of the Indian elderly—surveyed in a sampling of 622 people—71 percent have received hospitilization for illnesses within the past 12 months; 52 percent of those were currently taking medication for existing health conditions; 32 percent of them were ill at the time of the interviews; and 31 percent had been hospitalized for health conditions in the past 6 months.

A NICOA study found in 1980 that out of more than 700 Indian elders surveyed 71 percent had great difficulty in just performing the basic rudiments of daily living.

Another recent survey by NICOA has shown that the Indian elderly live in substandard and unsafe housing, and their lives are almost in daily jeopardy due to an unsafe and poor housing environment. Statistical evidence on which I base this statement is contained in my written remarks.

As regards the level of services, I think that there is such a multiplicity of services that many of us assume that all the needs of the Indian elderly are met and they're adequately monitored. This is not so. The so-called continuum breaks down through the lack of coordination among the many different services which now exist.

We see the need for in-home health care as being the single most important need among the Indian elderly, both reservation and urban based, because of the many barriers which exist to getting to the services in both settings. The support of the Community Health

Representatives Programs is vital to provide supportive services to the home health care agencies and a very important linkage, lifeline, to the native American elderly population. Nutrition services, another important aspect of the continuum of health care and promotion, are available only on a very limited basis, one-fourth of the tribes in our country. And these one-fourth of the tribes in our country having title VI grants can serve only 50 percent of their populations.

You will hear statistics later on that would indicate that most of the Indian elderly are having their nutritional needs met. This is not so. We know that from our own surveys. We know it from reports from title VI program directors, and also from the fact that only one-eighth of the Indian population is receiving title VI services. The remainder having to be served by title III. We know that the level of participation of Indian elders in title III services is less than 1 percent.

We're not angry at the service providers, at AOA or at IHS or HUD or BIA or any others who provide services for Indian elderly. We're grateful. We're extremely thankful for all that these people are doing. For their dedication and their commitment, for the utilization of funds and services. We're very thankful for that, Senator Bingaman, but it's time to be honest about the statistics. It is time to be honest about the facts which exist. About the level of needs and the level of services, and it's time for a new level of commitment. It's time for us to work together, to meet the needs of Indian elderly people.

The witnesses which follow will specify some of the detailed services which are very much needed. We need change, Senator Bingaman. We need a revolution. Not militant radicalism of days gone by, but an honest confrontration of the facts, an honest dealing with the policies which now exclude Indian elderly people from needed services. We need major changes through a sane and sensible legislative process. We need changes in attitudes. Unfortunately, Senator Bingaman, there are some in our service delivery system who simply don't care.

We're here, Senator Bingaman, because we care. You're here because you care. We want to say that we need change in the service delivery system. I have documented those changes and made some recommendations, which I won't refer to at this time. But, Senator Bingaman, more than anything else we need you as an agent of change. We need your help, because we can't do the job alone.

We need help from the top. We need help from the grassroots level. We need help throughout the so-called continuum of health care for Indian elderly. We need the help of these service providers, and the help of every Indian elderly's family. We need the help of all people who have a heart for the concerns and the needs of their fellow man. Senator Bingaman, we need help today, and that's why we're here.

I want to submit the written text of my testimony for the record, and I will be glad to answer any questions that you might have. Thank you.

[The prepared statement of Mr. Cook follows:]

STATEMENT OF CURTIS D. COOK
EXECUTIVE DIRECTOR
NATIONAL INDIAN COUNCIL ON AGING

Senator Bingaman, it is a privilege for me to present testimony here before you today. I am Curtis Cook, Executive Director for the National Indian Council on Aging -- an organization formed by the Indian tribes in 1976 for the purpose of advocating for Indian and Alaskan Native elders.

Let me say, at the outset, Senator Bingaman, that in my contacts with Indian people from North Carolina to California, as well as throughout the State of New Mexico, you are considered to be one of the best and most responsive of our friends in high places, and we want to thank you sincerely for all you are doing on our behalf.

The testimony I will present before you today is based upon several studies which I have listed in a bibliography accompanying my written testimony. Since there is not time to cite all of those studies at this hearing, I would like to request that the list be included in the formal record. One of the studies to which I refer is a survey conducted in the past eight months by the National Indian Council on Aging, which was designed to determine the status of Indian elders with regard to their health, housing and safety. I can only touch on the highlights of our findings, and make reference to the information contained in the other studies. I believe you will discover, upon further examination of those referenced studies, that they either confirm or magnify the conclusions we have drawn from our study.

To generalize the findings of this and the other studies: we find that the greater majority of Indian elderly, whether on reservations or in urban areas, live day to day in almost unbelievable need and jeopardy in the areas which are most critical to proper health promotion. Typically, they live in sub-standard housing, failing health, social and geographic isolation, and abject poverty.

More specifically, our recent NICOA survey and the studies to which I refer in the bibliography, reveal the following alarming facts:

-- as high as 87% of the 620 elders included in the recent NICOA survey had incomes which are below $400 per month, and most depend on Supplemental Security Income as their sole source of support (NICOA, 1986); and 44% of those had incomes less than $200 per month;

-- the 1980 census has revealed that 61% of the nation's

Indian elderly population exists below the national poverty level;

-- 26% of the Indian elderly surveyed by NICOA in 1980 were living in homes which were constructed prior to 1939, and which were typically in a sad state of repair (NICOA, 1981); as confirmed in the more recent NICOA housing survey. We found that:

    25% have outdoor restrooms, and 24% have no indoor plumbing;

    42% had one to four broken windows, and 35% had broken doors; 31% had had their homes broken into, and 75% did not have telephones to use for calling for assistance in an emergency.

It is, therefore, no surprise to us that 29.8% did not feel safe and secure in their own homes, and 79.3% felt insecure about leaving their homes overnight.

In terms of their health, our study found that:

-- 71% of the respondents had seen a doctor in the past six months to receive treatment for illnesses, and nearly one-third (1/3) had been hospitalized in the preceding twelve months;

-- 52.5% were taking medications for existing health conditions, and 32% were ill at the time of the survey (NICOA, 1986).

The 1980 census indicated that the life-expectancy of Indian people is eight (8) years less than that of the general population.

The Technical Report of the White House Conference on Aging in 1981 reported that as high as 40% of the adult population on some reservations is afflicted with diabetes; and our recent survey found that as many as 50% of the elders on some reservations suffer from painful arthritic conditions. Again, it is not surprising, in view of these statistics, that Indian elderly also experience an exceptionally high incidence of attendant debilitating conditions. When this information is coupled with the poor housing and safety conditions revealed through our recent studies, it is clear that the Indian elderly are in serious jeopardy, and in many cases are living day to day in very life-threatening circumstances. The 1980 utilization by NICOA of the Older Americans Resources and Services (OARS) survey instrument revealed that 71% of the Indian elderly respondents suffer limitations in their ability to perform the activities of daily living due to chronic and degenerative diseases (NICOA, 1981).

In terms of mortality among the nation's Indian population, the figures are equally alarming. A recent informational paper prepared by Senator Heinz' Senate Special Committee on Aging (Heinz, 1986) related the following mortality statistics:

-- Indian deaths from alcoholism are 459% higher than the U.S. all races population;
-- Indian deaths from tuberculosis are 233% higher;
-- from accidents, 155% higher;
-- from diabetes, 107% higher;
-- from pneumonia and influenza, 66% higher;
-- from homicide, 66% higher.

While we do not have a specific breakout of the incidence of these causes of death among Indian elderly, it is obvious that the elders find themselves in an environment which is not conducive to good health promotion nor to longevity.

A study conducted by the National Indian Council on Aging and published in 1983 identified the barriers that reservation and urban Indian elders face in gaining access to various entitlement services which are important to adequate health promotion. NICOA proposed specific action plans and models which, if applied, would increase the access of these elders to the services they need; however, the plans have yet to be implemented.

All of the above findings and statistics summarize what we know today about Indian elderly health; however, more complete infor mation is needed on the health status of the elderly Indian population. This can be obtained through a more comprehensive clinically-based, as well as field-oriented, research effort which is aimed at designing programmatic strategies and policies which will have a corrective and favorable impact on these problems which so often plaque the Indian elderly and devastate their lives.

Also needed are better methods of coordinating and upgrading the various services which now exist. For example: the Title VI meal sites, which provide nutrition for Indian elders in 124 of the more than 500 federally-recognized Indian tribes in the country, could become centers for health screening and monitoring, health maintenance and promotion, and health education and prevention, as the participating elders are present and available on a daily basis to be seen by visiting service providers. On the other hand, the services provided in the homes of the elders by Community Health Representatives (CHR) could be up-graded with proper training to include higher levels of direct health care delivery; or the basic CHR health monitoring and maintenance activities could be supplemented by professional home health care delivery programs. In either case, the CHR services, which have been repeatedly targeted for elimination from the federal budget, must be retained as a vital life-line for the elders who would receive no services at all if these programs were dropped.

There are many other needs, gaps in services, and barriers which we could cite; but the evidence is clear: Indian elders who are at risk and vulnerable must have the assistance and commitment of researchers, medical and social service professionals, policy makers, legislators, advocates, tribes and families in order to halt the seemingly uncontrollable trend toward deteriorating conditions which unfortunately runs concurrent with a growing insensitivity and budget-cutting obsession within the federal government. The inevitable outcome, if these trends are permitted to continue, will be that these who are undeniably among the most needy people of our country will be further deprived of services and programs which are essential to their ability to live out their lives in dignity and good health.

Recommendations

Recognizing the almost overwhelming level of need which persists among the Indian elderly, the National Indian Council on Aging recommends the following:

1) The National Institute on Aging, National Institutes of Health, or the American Association of Indian Physicians should be approached and funded for the express purpose of conducting a nationwide research effort to provide clear and comprehensive documentation of the health conditions of the Indian elderly, includ-

ing their mental health and the other conditions which mitigate against their ability to live happy and healthy lives.

2) Organizations such as the National Indian Health Board, and the National Indian Council on Aging should be consulted and directly involved in the research effort and in the formulation of recommendations and action plans which may arise out of the research findings.

3) An inter-agency task force should be formed and mandated to investigate national Indian aging policy considerations and the entire continuum of health care affecting the lives of Indian elderly. This task force should include and involve the National Indian Council on Aging.

4) Senate Bill S-277, or the bill for the reauthorization of the Indian Health Care Improvement Act, should include a gerontological focus and appropriations which will facilitate the development and implementation of research and other programs to address the needs of Indian elderly nationwide.

5) The Community Health Representatives (CHR) programs must be retained and protected in the reauthorized In-

The following is a Bibliographical listing of the major studies documenting the status of Indian and Alaskan Native elderly persons, and is to accompany the statement of Curtis D. Cook, Executive Director of the National Indian Council on Aging before Senator Jeff Bingaman on September 03, 1986 in Santa Fe, New Mexico.

The Continuum of Life: Health Concerns of the Indian Elderly, Final Report on the Second National Indian Conference on Aging, Billings, Montana, August 1978, 205 pages.

ACCESS: A Demonstration Project, Entitlement Programs for Indian Elders, Final Report, 1983, 88 pages.

Indian Elderly and Entitlement Programs: An Accessing Demonstration Project, 1981, 96 pages.

American Indian Elderly: A National Profile, 1981, 185 pages.

Technical Report of the 1981 White House Conference on Aging, 1981, 12 pages.

National Indian Policy on Aging, Draft, Submitted to Administration on Aging, July, 1984, 43 pages.

National Indian Aging Policy, Draft, Submitted to Congressman Ed Roybal's Office, March 1985, 10 pages.

Informational Paper: Elderly American Indians/Alaskan Natives, United States Special Committee on Aging, February, 1986, 11 pages.

A Survey of Indian Elderly Housing, Safety and Health, pending publication by the National Indian Council on Aging, October, 1986.

Health and Aging Among American Indians: Issues and Challenges for the Bio-behavioral Sciences, Institute on Aging, Portland State University, April, 1985, 76 pages.

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SUMMARY OF FINDINGS
OF THE
NICOA HOUSING, HEALTH AND SAFETY SURVEY

In the months of January through March, 1986 the National Indian Council on Aging conducted a survey to determine the status of Indian elderly persons with respect to their housing, health and safety. The survey was conducted by means of personal interviews with Indian elderly people at three primary sites: the Papago and San Carlos Apache reservations in Arizona, and the Zuni reservation in New Mexico. In order to enlarge the data base and to confirm the findings at the three primary sites, the survey was expanded to include the elders of tribes in several other states: Oklahoma, Nebraska, Kansas, Minnesota, South Dakota, Idaho, Washington and California. In all 622 survey questionnaires were completed.

Here is a summary of the findings of those surveys:

PERSONAL DATA

22.6% of the respondents were male
77.4% of the respondents were female
92.3% were 60 years of age or over
14.4% never went to school
25.7% had at least 8 years of schooling
50.0% had less than 8 years of schooling
10.0% did not respond to this question
44.7% did not speak or read English
42.5% had incomes of $200/month or less
44.5% had incomes of $201/month to $400/month (making a total of 87% with incomes less than $401/month)

HOUSING

66.8% had 3 or more persons living in their home
76.1% had less than 3 bedrooms
24.0% had outdoor restrooms
16.4% had no indoor plumbing at all (another study (NICOA, 1981) shows that 26.3% of Indian elderly homes nationwide do not have indoor plumbing)
42.1% had 1 - 4 broken windows
35.0% had broken doors
75.0% had no telephones
13.4% had no refrigerator
48.4% had wood stoves for cooking and heating

46.3% lived in (older) traditional housing
49.4% had areas of the home with no floor covering of any type

HEALTH

71.1% had seen a doctor for illness in the preceeding 6 months
30.0% had been hospitalized for illness in the preceeding 12 months
15.5% of those surveyed reported that they had diabetes (this figure ranged as high as 40% on some reservations)
50.0% (on some reservations) suffered from arthritis
52.5% overall were currently taking medication for existing health conditions
31.9% were currently ill
16.4% were physically disabled
51.4% had poor-to-fair hearing, while only 9.5% had hearing aids
50.4% had poor eyesight

SAFETY

14.4% had recently suffered accidents resulting in injuries
80.4% had no smoke alarms in their homes
86.6% had no fire extinguishers
72.1% of those who had gas stoves had not had them checked for leaks in the preceeding 12 months
20.6% have to use steps to enter and exit their homes
16.4% have no porchlights
15.4% of them cannot lock their doors from inside
21.6% cannot lock their windows
30.9% had their homes broken into
81.4% of the homes were located "far" from a fire hydrant (more than ¼ mile)
29.8% did not feel safe in their homes, and 79.3% felt insecure about leaving their homes overnight

CONCLUSIONS

Even a cursory examination of the findings of the survey reveals certain disturbing facts about Indian elderly daily life and the extent to which their needs exist. We were already aware that they were at risk in several areas, but the prevalence of conditions which jeopardize their well-being is alarming.

For instance, the combination of the following factors makes it clear that many of them run the risk of serious injury or loss of life: many are disabled, living in homes which are full of safety hazards, and have no telephones for calling for help in an emergency. Their health is generally poor, and they must have frequent monitoring of their condition as well as treatment. Some programs which are very much needed by these elders are either no longer available or are being targeted for elimination from the federal budget (eg., eyeglasses, dentures, hearing aids, and in-home care by CHR's). Many of these elders live in harsh climates with inadequate heating and indoor facilities: the need for a disabled elder, with poor eyesight to go out of his or her house down a number of steps, which may be covered with ice in the winter, just to use an outdoor restroom facility places this elder in a precarious set of circumstances. Other such combinations of interacting conditions make normal daily living a very difficult task for many of these elders.

A major effort is needed to sensitize tribes, service providers and informal support groups to the inordinate levels of need which exist among their elders, and to develop strategies which will help to ameliorate some of these threatening curcumstances.

Senator **Bingaman**. Thank you very much for that informative testimony. Let me ask a general question. You state in your written testimony that there is a need for a national Indian aging policy in this country. Why do we need a national Indian aging policy? What would a national Indian aging policy consist of? And why a national Indian aging policy and not a national aging policy in general?

Mr. **Cook**. Specifically because of the gaps in the coordination of services, and the gaps of the so-called continuum. There is a lack of coordination between service agencies in which Indian elderly persons fall through the cracks in the service delivery system. Also because we believe that a minimum set of standards for the delivery of health care and other services to Indian elderly people in our country will ensure or at least assist toward a better life style for the Indian elderly. It will require service agencies to perform up to their mandates as written in the law.

Our contention is that the services provided, while they're good, are not good enough. Indian elderly have not been brought up to parity with the rest of the U.S. population, and that is the specific reason why we need a national Indian aging policy. That is the needs are unique. The needs are greater, and the problems and barriers they face are unique. The national Indian aging policy would centralize the focus of those needs. Would centralize services. Establish an interagency task force to address the concern of the Indian elderly people, and would provide a level of services which would greatly enhance the situation which now exists.

Senator **Bingaman**. Thank you again very much for your excellent testimony. I appreciate it. As we go through the day I'm sure many of the specifics that you referred to will be highlighted in other testimony. Thank you very much.

Mr. **Cook**. Thank you.

Senator **Bingaman**. Let me now call up the first panel. This panel of tribal leaders and senior citizens will give us the tribal perspective. Members of this panel are: Alcario Chavez, who is the Lieutenant Governor of Sandia Pueblo.

James Hena, who is representing the Eight Northern Indian Pueblo Council.

Ron Tso, who is the acting deputy director of the division of health improvement services for the Navajo Nation.

Evelyn Breuninger, who is the secretary of the Mescalero Apache Tribal Council.

And Cora Gomez, who I understand was unable to join us, but who was invited to represent the Jicarilla Apache Tribe.

With that why don't we just go ahead and start. We will take you in the order I have introduced you so if Alcario Chavez with the Sandia Pueblo will please go first.

STATEMENT OF ALCARIO CHAVEZ, BERNALILLO, NM, LIEUTENANT GOVERNOR OF SANDIA PUEBLO

Mr. **Chavez**. Mr. Bingaman, I appreciate the opportunity to be here. My name is Alcario Chavez. A lot of my friends don't know me by my real name. They call me Archie. I am Lieutenant Governor of the Sandia Pueblo. In the audience with me is our Governor, Mike Avila.

Mr. AVILA. Senator Bingaman.

Senator BINGAMAN. Thank you, Governor.

Mr. CHAVEZ. Mr. Bernie Trujillo, chairman of our Elderly Program. Also in the audience are some people from Sandia. By the way, all senior citizens. We have a statement that we would like the committee to hear today.

Sandia Pueblo is one of the five Sandoval Indian Pueblos consortium, and we are the closest of these pueblos to a major hospital in Albuquerque, and also have the smallest population. The other members of the Sandoval Pueblos consortium are Cochiti, Jemez, Santana, and Zia. Sandia's total population is 371—270 of those people living on the reservation of whom 43 of those are elderly. Our community makeup is educational for deciding whether closeness to city hospitals and medical services with smaller numbers of elderly Indians; is this a significant factor in improving the quality of health care on Indian reservations.

While helpful, the closeness to medical facilities and services and smaller population do not automatically overcome the problem of adequate health care for elderly Indians. Senator, the problem is the lack of quality and quantity of health care among the Indian people.

Recent surveys by NICOA, and you heard Mr. Cook's previous testimony, have documented that administrative barriers exist that restrict the elderly Indians from receiving medical services for which they are eligible. Medicare and Medicaid access to the Indian elderly is a problem that is highlighted in my written testimony.

We support the focus of the Indian Health Promotion and Disease Prevention Act of 1985, and continue to believe that legislation is the direction that Indian health care needs to take.

This is also the case for elderly Indian and especially if that legislation has inclusion of health promotion and disease prevention services within that program. To us that is a very important program. The CHR Program is very important now for health care for the elderly Indians, even with reduced funding that the Indian Health Service is asking Congress to give to the program. Enhanced program would improve the necessary funding of CHR's, which is a primary vehicle for health care for the elderly.

We, therefore, urge you and other members of the Special Committee on Aging to be advocates in the 100th Congress for: First, increased programmatic authority for the CHR Program; and second, increase appropriations beyond the $26.5 million level provided in the Department of the Interior's appropriation bill for fiscal year 1987.

We ask that they lift the mandate that CHR's limit the transportation of elderly Indians, for nonemergency, outpatient care. We see a major problem in that. This effects the ability of CHR's to transport the elderly to important needs such as foot care, eye examinations, x rays, and dental needs. We ask that you inquire of IHS whether or not this tranportation restriction would be lifted. The CHR Program has specific funding set aside for this purpose.

The IHS appropriation justification for fiscal year 1987 states that the transportation is essential for health care to the Indian elderly.

Another way in which to focus on the CHR is to facilitate access to available health care for the elderly Indians is to increase the time spent by registered nurses on onsite Indian home care. For example, an IHS registered nurse now comes to Sandia Pueblo twice a week generally spends time checking immunization records and providing health education in maternal and child-related areas. While these activities are needed, they seem to limit time for very extensive home care for Sandia elderly.

We ask you to seek a line item setting aside for the 1988 CHR budget that will permit the registered nurse to spend at least 4 days a week at Sandia. This proposed line item set-aside would restore the registered nurse, field nurse, services to about the level that existed before the Reagan administration began seeking to eliminate the CHR Program from the Federal budget.

Yet another example of how decreased access by CHR's to transportation at least to health care problems is inadequate number of dental visitations for the elderly. Many Sandia elderly do not drive, therefore have a problem getting to Albuquerque for dental appointments. Due to the missed appointments Southwest Indian Politechnic Institute [SIPI] apparently has instituted a policy of penalizing the Sandia elderly who miss two appointments by denying them another appointment until 1 year later. We ask you to inquire into this matter and seek a resolution that permits CHR's to transport Indian elderly to this and related appointments.

We also ask you to seek clarification from IHS of the impact on the availability of needed elderly health care from the announcement that an exhibit to this prepared statement. This recent Federal announcement has generated confusion at Sandia Pueblo about the eligibility of our elders for the service under Medicaid and Medicare.

Thank you again for this opportunity to testify and give our recommendations as to how health care for elderly Indians can be improved.

[The prepared statement of Mr. Chavez follows:]

MR. MIKE AVILA
Governor

MR. ALCARIO CHAVEZ
Lt. Governor

MR. JOSE R. TRUJILLO
Treasurer

PUEBLO OF SANDIA

Box 6008
Bernalillo, New Mexico 87004
(505) 867-2876/5021

STATEMENT OF LT. GOVERNOR ALCARIO CHAVEZ, PUEBLO OF SANDIA BEFORE THE SENATE SPECIAL COMMITTEE ON AGING FIELD HEARING ON THE CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS, 03 SEPTEMBER 1986, SANTA FE, NEW MEXICO.

Mr. Chairman, I appreciate the opportunity to be here today. My name is Alcario Chavez. I am Lieutenant Governor of the Sandia Pueblo. With me is our Governor, Mike Avila, and Bernardino Trujillo, Chairman of our Elderly Program.

Sandia Pueblo is one of the Indian Pueblos composing the Five Sandoval Indian Pueblos consortium, and we are closest to a major hospital in Albuquerque and are the smallest population tribe in the consortium. Sandia has a total population of 371 people and a resident population of 270 of whom 43 are elderly persons aged 55 and over. Our demographics can serve to dispel any notion that relative closeness to metropolitan hospitals and medical services (as contrasted with rural, more isolated reservations), and fewer numbers of elderly automatically elevates the quality of health care provided elderly Indians.

While proximity of facilities, services and a smaller service population is helpful, the problem of the Indian elderly at Sandia, and on other reservations, is the lack of quality and quantity of health service provided.

Statistics on the inadequacies of health care for elderly Indians are available. Recent surveys by the National Indian Council on Aging (NICOA) are a source for this information. NICOA's testimony today, and from other hearings and forums, has served to document that administrative barriers exist to reservation elderly Indians receiving services which federal law, otherwise, makes them eligible for. (For example, Title III of Administration on Aging, the congregate meals program, and Medicare and Medicaid, are generally not accessible to the Indian elderly.)

Sandia Pueblo testified before you last year in support of S.400 - Indian Heath Promotion and Disease Prevention Act (Senate Select Committee on Indian Affairs Field Hearing, 01 June 1985, Gallup, New Mexico), and continues to believe the focus of that legislation is the direction that Indian health care, including that for the elderly, needs to assume. S.400 proposed inclusion of health promotion and disease prevention services within the Indian Health Service, and continuation and improvement of the Community Health Representative Program (CHR) as the vehicle to carry out such health promotion activities.

It is regretable that the current administration, rather than enhancing the quality and quantity of services available to elderly Indians through the CHR program, instead, tries to eliminate this vital but inadequately funded program by annually seeking zero or greatly reduced appropriations for this line-item in the IHS request to Congress.

We commend your foresight in urging Congress to see the CHR program as the primary vehicle for upgrading Indian health care, including for the elderly. We urge you and your colleagues on the Special Committee on Aging to be advocates in the 100th Congress for (a) increased programmatic authority for the CHR program, and (b) appropriations beyond the $26.5 million FY 1986 base, maintenance level included in HR 5234, the Department of the Interior and Related Agencies Appropriation Bill for FY 1987. (Reference House Report 99-714 dated 24 July 1986 accompanying HR 5234.)

CHR program effectiveness, at Sandia Pueblo, has been hampered by the reduced funding brought on by the current administration's efforts to eliminate this program from theIHS budget. A mandate that CHR's limit the transportation of elderly Indians, for non-emergency, outpatient care, isshortsighted and unwieldly. This transportation limit applies to important needs such as podiatry, eye clinic, X-rays and dental needs. This limitation has been imposed at Sandia Pueblo despite the FY 1987 IHS Justification of Appropriations Estimates statement, at Page IH-88, as follows:

> "...Non-emergency transportation is still essential to the provision of health care, especially to the elderly and those in rural settings."
> (See Exhibit I of this Statement.)

We invite the Committee's inquiry into this apparent inconsistency between IHS stated policy (in the Appropriation Justification) and IHS practice, at least at the Albuquerque Area Office.

One possible remedy, to the problem of providing access to available medical service and facilities for elderly Indians, could be to increase the time spent by Registered Nurses (RN) in onsite, reservation in-home care. For example, an IHS RN now comes to Sandia Pueblo twice a week and spends a majority of time checking immunization records and providing health education in maternal and child-related areas. The RN does not, however, provide very extensive in-home care to the Sandia elderly. This missed opportunity for health promotion and disease prevention could be remedied by at least doubling the amount of time the RN would spend solely on the needs of the elderly.

This proposed remedy is a funding rather than a policy issue. Sandia Pueblo, not-so-many years ago, had an RN field nurse come to our Pueblo four times a week. We recommend, that this Committee be an advocate for a line-item earmark (CHR or otherwise), in the FY 1988 IHS Budget, for needed registered nurse, in-home care services to the Indian elderly.

Another problem resulting from decreased access by CHR's to transportation that is necessary to give the elderly adequate access to needed outpatient care is inadequate dental visitations. Since many elderly patients do not, or should not, themselves drive, decreased CHR transportation has apparently lent itself to a decision by the Southwest Indian Polytechnic Institute (SIPI) to penalize elderly patients who miss two dental appointments in one year's time. SIPI has [illegible] policy of penalizing the Sandia elderly who miss two appointments by denying them another appointment until one year's time has elapsed. We ask for your inquiry into this matter which could be remedied by permitting CHR's to transport Indian elders in non-emergency situations.

The problem with access to the Medicaid and Medicare program could also perhaps be remedied somewhat by Congressional [illegible]. **Exhibit II** to this Statement is a recent notification procedures from the Department of Health & Human Services, Social Work Service Administration, Albuquerque Service Unit, pertaining to "Social Work Service Policy and Procedures." This announcement has confused elderly people at Sandia Pueblo, insofar as eligibility for and/or services provided them under Medicaid or Medicare. The announcement states, in part, that:

> "As computerization systems develop Health Care Review office will utilize State Medicaid listings with Indian code (04) to extrapolate data on eligible Indian people. Health Care Review will notify by letter and follow-up those who are becoming 65, as to what resources they are becoming eligible for (SSI-Medicaid, etc.). Complicated cases or those not covered by any known resource will be referred to appropriate tribal services or to Social Work Service at Albuquerque Indian Hospital for investigation and referral as deemed appropriate."

And we similarly seek your help to clarify for our elderly this announcement's impact on provision of these vital services.

This concludes our prepared remarks and we would be pleased to respond to any inquiries you may have at this time.

EXHIBIT I

STATEMENT OF SANDIA PUEBLO
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING FIELD HEARING
03 September 1986

FISCAL YEAR 1987

Volume X

Justification of Appropriation Estimates for Committee on Appropriations

Indian Health

(d) Community Health Representative (CHR)

	FY 1986 Appropriation BA	FY 1986 Available after Sequestering BA	FY 1986 Revised Estimate BA	FY 1987 Estimate BA	Increase (+) Decrease (-) BA
Direct Appropriation.	$25,844,000	$25,585,000	$14,500,000	$ ---	-$14,500,000
Reimbursements.	---	---	---	---	---
Total	$25,844,000	$25,585,000	$14,500,000	$ ---	-$14,500,000

Purpose and Method of Operation

The CHR Program was implemented to improve the health knowledge, attitudes and practices of Indian people by promoting, supporting, and assisting the IHS in delivering a total health care program. The efforts of the CHR program staff have produced an Indian and Alaska Native health service delivery system which provides for follow-up and continued contact with the health care delivery system at the community level, thereby meeting the most basic needs of the Indian and Alaska Native population.

The goal of the program is to address health care needs through the provision of community-oriented primary care services, including traditional native concepts in multiple settings, utilizing community-based, well-trained, medically-guided health workers.

The CHR program has allowed tribal governments to address their health care priorities in keeping with the intent of self-determination legislation. The program has demonstrated accomplishments in the areas of patient utilization of health services, tribal health program development and direct health care delivery.

An example of one of the most dramatic influences of the CHR program in tribal health delivery of direct health care is demonstrated by the accomplishments in Tribal emergency medical service programs and the immunization initiative. Many community based CHRs are EMT instructors and EMTs who provide the staff for the management and operation of ambulance service for Indian communities. In addition, others are trained as First Responders and equipped with mobile radios and medical kits. Without the active involvement of CHR personnel, many tribal ambulance service programs will not survive.

Many other essential health services are provided by CHRs. Non-emergency transportation is still essential to the provision of health care, especially to the elderly and those in rural settings. Information, education and technical assistance to effect a reduction in accidents and health hazards has effectively reduced health care and hospitalization needs.

Accomplishments

Since the mandate by the 97th Congress for more accountability of CHR program resources, the IHS has developed a uniform scope of work and is field testing a mandatory reporting system, the Community Health Representative Information System (CHRIS), which is being implemented by all tribal contractors receiving CHR program resources. This is the beginning of the process to evaluate cost effectiveness, which leads into the Resource Requirement Methodology (RRM) for the allocation of CHR programs resources.

Preliminary analysis of the data collected in FY 1985 reveals that the cost per CHR encounter (group and individual) was $3.18.

The FY 1986 revised estimate of $14,500,000 will purchase 4,559,296 encounters from 1,500 CHRs through March 31, 1986.

FY 1987 Budget Proposal

Funded from Direct Appropriation

Program Decrease -$14,500,000

The FY 1987 request proposes elimination of the Community Health Representative Program in an effort to focus scarce federal resources on maintaining key inpatient and outpatient medical care services.

Impact Data

	1985 Actual	1986 Revised 1/	1987 Estimate
Encounters (Individual and groups of individuals).....	8,012,579	4,559,296	---

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1/ Represents 6 months of service.

EXHIBIT II

STATEMENT OF SANDIA PUEBLO
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING FIELD HEARING

03 September 1986

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date July 30, 1986

From Social Work Service Administration
Albuquerque Service Unit

Subject Identification and Enrollment of People 65 and Older for SSI-Medicaid and Medicare

To Social Work Service Policy and Procedures, JCAH Files

ATTENDANCE: Carlotta Romero, Coy Davis, Roberta Zuni

The following procedures will be followed to identify alternate resources for senior citizens:

1. As computerization systems develop Health Care Review office will utilize state Medicaid listings with Indian code (04) to extrapolate data on eligible Indian people. Health Care Review will notify by letter and follow-up those who are becoming 65, as to what resources they are becoming eligible for (SSI-Medicaid, etc.). Complicated cases or those not covered by any known resource will be referred to appropriate tribal services or to Social Work Service at Albuquerque Indian Hospital for investigation and referral as deemed appropriate.

2. In view of the above and to avoid redundancy Social Work Service at AIH will discontinue making home visits for the sole purpose of identifying alternate resources, but will upon referral from Health Care Review assist needy patients with resource referrals as part of an overall casework treatment plan.

3. Social Work Service at AIH will, if requested by patients, act as representatives for those patients planning to appear before appeal boards of the Social Security Administration. The Social Work Service at AIH will also initiate SSI, welfare, food-stamp, etc. applications for inpatients and outpatient when necessary as part of a total casework treatment plan.

C. Davis
Coy A. Davis, ACSW

cc: Attendees
SWS Staff, AIH
Dr. Chuck North
Vesta Starkey, ACSW

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
PHS Indian Hospital
801 Vassar Drive N. E.
Albuquerque New Mexico 87106

PATIENTS
NAME____________________ MEDICAL RECORD #__________ DATE __________

The following information is needed for eligibility of medical services and for billing purposes.

☐ Degree of Indian Blood Certificate:____________________

☐ Name of Insurance Company:____________________

☐ Insurance Policy Number:____________________

☐ Group Policy Number:____________________

☐ Name of Insured:____________________

☐ Insurance Company Address:____________________

☐ SOCIAL SECURITY NUMBER:____________________

☐ Effective Date of Insurance:____________________

☐ Employment of Insured:____________________

☐ Address of Employment:____________________

☐ Medicare Number:____________________

☐ Medicaid Number:____________________

XXX Other: PLEASE SIGN ATTACHED "ASSIGNMENT OF MEDICAL BENEFITS"

Return the form in the self-addressed envelope provided for your use.

Thank you.

Medical Records Department

Senator BINGAMAN. Thank you very much, Mr. Chavez. I appreciate it.

Mr. Hena, I'm glad you're here. Thank you.

Mr. HENA. Thank you, Senator. My name is Jim Hena. I'm the go-for for the Tesuque Pueblo. I was asked by the Governor of the Ildefonso Pueblo, Governor Sanchez, to testify before this committee this morning. And if you don't mind, Senator, I would like the representatives of the Eight Northern Indian Pueblos who are present to stand, to indicate how many are present. Would you, please?

Senator BINGAMAN. We appreciate all of these folks coming very much. Thank you.

STATEMENT OF JAMES HENA, SANTA FE, NM, REPRESENTATIVE, EIGHT NORTHERN INDIAN PUEBLOS COUNCIL

Mr. HENA. Thank you, Senator. I think it demonstrates the concern that the elderly people in the Northern Pueblos have with regard to health care activities regarding their personal health, and so forth.

You have my written text, and I'm just going to make some comments off the cuff regarding some of the points made in the written testimony. I think that we all know that society changes from time to time, depending on technological changes, changes in attitudes, and so forth. With regard to that, I think the most significant changes that took place as far as attitudes, morality, values, and so forth, are concerned among Indian people and especially in this case the elderly was during the early 1970's when, I guess, due to the philosophy of the so-called flower children and so forth; attitudes within this country, with respect to obedience, respect, and so forth, changed substantially.

These same changes effected Indian communities. The traditional respect that has held for elderly people by the young people changed substantially so that today we find the same kinds of problems confronting our tribal government on various pueblos and reservations. I think this is primarily due to change in attitudes among young people about values, about obedience, about respect, about caring for one another. And the necessity for coordinating family relationships between the young and old and all those in between. I think those strengths that have kept the Indian communities going since the discovery of America by Columbus tend to be undermined and eroded during these times.

I think these are some of the reasons why today we find within our Indian communities some problems that we need to look at in terms of providing services to our elderly folks in terms of our governmental responsibilities. In that sense you mentioned continuum of care. I was reading your opening remarks, and I was remarking to my technical assistants that I think I will just read the Senator's opening remarks back to him and present that as my testimony, because I think you covered just about everything quite well.

I think in terms of continuum care what we're talking about is a wholistic approach to the needs of the elderly. Again, thinking back to how we used to live in the pueblo from which I come from, I as a young child had relationships with my grandparents, my extended relatives and all of the elderly people. The leaders, and so forth, in the community.

There was also someone that I could turn to for advice and so forth besides my my own parents and sister, and so forth. I think this is what is needed today. Our elderly people are lacking, perhaps, proper medical care, access to medical facilities because of lack of transportation, and so on. But I think the real problem is that they are also sort of left out in left field. Their attitude may be that they're incapable of making a contribution to the community in terms of their experiences, and what have you. I think that's a mistake.

I for one would like to see a program which offers a wholistic approach, so that there is a return to the old style of living among the pueblos' elders, young people and everybody else in between, and make these communities as cohesive as possible so that everybody's will to live and to abide by rules and regulations and respect, and so forth, are improved rather than unregarded or degraded.

In terms of some of the comments I'm making come from the elderly folks' meeting that was held on June 16, in which case they made these comments and prioritized them and presented to the Indian Health Service. One of the concerns that they have expressed is the need for a geriatrician in the hospital, because of the increasing number of elderly people that are now coming to the Indian hospitals. There are not people that are trained in this particular area to provide the particular and unique needs of the elderly. Therefore, it's recommended that perhaps your office together with Indian Health Service work on some plan to analyze the needs of these kind of physicians and begin to establish the kinds of positions that will meet these special health care needs of the elderly in these clinics and service units that we have in New Mexico.

We have about three health clinics within the Northern Pueblos. These serve a very broad purpose, but I think the significance of the role that they serve is because of their accessibility. Because like has already been indicated by other presenters, transportation is a necessity that very many of the elderly don't have. Where you have a clinic within walking distance or within, say, a 2- to 3-mile drive, when you find relatives who are not occupied with employment, and so forth, they can take you there. So these local health clinics are serving a broad base need but particularly are doing well because of their accessibility, and these services need to be continued.

As far as the community health representatives are concerned, I think since 1969, which was the first year that this program was implemented, they have done a tremendous amount of work within the community providing the various kinds of services that they do provide. And I think that needs to be continued. Again, going back to the lack of transportation, language barriers and so forth, the elderly seem to feel more comfortable in dealing with one of they're own. Trying to get the kinds of services that those people provide as well as acting as interpreters and advocates when they have to go in to a health facility for recovery purposes.

One of the problems that I think the CHR is having is the tremendous amount of paperwork that they have to fill out. It seems like—and I say this jokingly—they even have to report every time they went to the bathroom. I mean, to me the bottom line is that we all should be concerned about responsibility and accountability for public funds. But I think some of these bureaucracies overdo it, so that a consequence is that the CHR representative is spending perhaps as much as half of their time filling out these very complicated forms, and you almost have to have a college education to fill out those forms, rather than being out in the field. And because most of these people are people who want to be out in the field and working one on one with elderly people and others who need these kinds of services, they tend to forget the importance of filling out these forms. If something could be done to at least reduce the number of forms that they have to fill out. I was surprised. I'm a business manager for my tribe. But when I check with CHR and saw the number of reports that she had to prepare, I was astounded. I think they're just being overloaded with paper requirements.

One of the significant needs that we have among the Eight Northern Pueblos is the ambulance services. Because we're situated in rural communities where many times we don't have paved roads and so forth, a lot of the ambulance service that operate out of the nearby cities will not come on reservations. Thereby requiring that we provide our own ambulance service. We did have a service the last few years, but because of funding problems, I think that program folded up recently. I think that if something could be done, either through the IHS or through some other Federal program. As I recall, I think it was the Department of Transportation that at one time had programs that dealt with ambulance services. So that might be something you could look into and maybe suggest to the Indian Health Service that they do something about that.

Another problem that elderly people complain about is premature discharge from the hospital. What this means is that when they enter into the hospital for some illness, I guess depending on whether or not they have Medicare and Medicaid and whether IHS in some fashion can recover its cost for providing those services to the Indian elderly; where they determine they can't recover costs, rather than keep a patient until fully recovered, they discharge that person back to their homes where they are not provided the kind of professional care that an individual might need. And what they're asking here is that some analysis; and if necessary an investigation be made of these practices within the IHS, and a stop put to it if that's the case.

I also would like to make some comments about one of the things that I feel is very important, that is the necessity to put the services the Indian elderly in this case are requesting in a perspective, which comes from the many treaties that Indian tribes entered into with the U.S. Government. A lot of citizens in this country complain about Uncle Sam providing this and that for the Indian people. The appearance is that these people think that Uncle Sam provides all the services simply because we're Indians. That's not the case, and I think you're quite familiar with that. We're provided these services because our forefathers gave up something in exchange for these kinds of services. I think that this ought to be recognized in Congress, and that we are simply not being provided this service as the rest of the citizenry. But we are provided these services because we gave up something. And I think that if that could be something that the Congress could accept that maybe the appropriations and the funding requests that are made by various Indian representatives might go more smoothly.

And last but not least, I'd just like to make a comment on the attempts by the Indian Health Service in requesting from Indian people responses about who should be eligible for Indian health services. I think the pueblos took the position since the U.S. Supreme court decision regarding the *Martinez* case rendered a decision that indicated that tribes were the only ones that could decide who were going to be members and so forth and not anybody else. That this is a roundabout way on the part of IHS to tell the Indians that we think that you ought to be changing your membership rolls and so forth.

And in closing I'd just like to thank you for your dedication to what you're doing with the elderly program and hope that you stay in the Senate to represent the elderly's interest. Thank you, Senator.

[The prepared statement of Mr. Hena follows:]

EIGHT NORTHERN INDIAN PUEBLOS COUNCIL

P.O. Box 969
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TESTIMONY GIVEN AT THE HEARING ON
HEALTH CARE FOR INDIAN ELDERS
ON SEPTEMBER 3, 1986 IN SANTA FE, NEW MEXICO

Good Morning.

My name is James Hena and I am the business manager for the Pueblo of Tesuque as well as a board member for the National Indian Council on Aging. I was asked to present this testimony concerning the health needs of our Pueblo Indian elders by the Chairman of the Eight Northern Indian Pueblos Council, Governor Gilbert Sanchez, who has other duties today. This testimony is a result of recommendations made by the Eight Northern Indian Pueblos' Elderly advisory board at a meeting on June 16th of this year. This Advisory board is comprised of elders 55 years and over who live among the Eight Northern Pueblos.

As we know, society changes, and so do the needs of everyone. This is particalary true for our pueblo elders who, until quite recently, lived a very traditional yet self sufficient and healthy lifestyle, but the recent technological changes which impact on societal lifestyle has generally had an adverse effect and affect on the physical and mental health of Native Americans. Perhaps most significantly these changes have been accompanied by deteriorating family and community relationships which in earlier times were the major source of support and care for everyone. Consequently, we are presently in dire need of more comprehensive services to assure adequate care for our elderly.

The concerns listed below are considered by the advisory board to be the most important and pressing health care needs for the Pueblo elderly today. In each area we have suggested action which could be taken. We implore you to study these concerns and recommendations closely as they each have critical bearing on the well-being of our elders. And because of our responsiblilites to our elders who have brought us this far and provide the link to our heritages their welfare is of utmost concern to us. Here then are the main concerns raised by the advisory board:

1. Continuum of Care: New options for care must be developed in addition to traditional care networks which are deteriorating. We advocate a "continuum of care "strategy which offers our elderly a variety of care options as well as maintains the elders' role in the home and community if physically possible. Specifically, the Board voiced support for "In-Home Care Services" which would meet the medical, social, emotional and environmental needs of the elders within their home seeting. There was also an expressed need for a health care facility specifically tailored to the cultural needs of the Northern Pueblos. This could be an "intermediate care" or nursing home facility cooperatively built and operated by IHS and the Eight Northern Pueblos. Therefore, it is recommended that your office work with the

Tribes and other federal agencies to establish a plan based on the continuum of care concept for integrating existing health services along with new programs and facilites to meet the full present and future health needs of the elderly and disabled.

2. IHS Geriatrician: Durning this decade, the elderly indian population is expected to double nation wide. This trend is definately visible among the Pueblos and should be reflected in the staff skills of our medical facilities. Therefore, it is recommended that IHS be required to establish positions or replace current positions with geriatric specialists and other trained in illnesses of the elderly.

3. Continuation of Health Clinics: Many of the elderly are without transportation and thus the health clinics within the communities of Taos, Santa Clara, and San Juan are critical basic IHS service sites. Every effort should be made to assure that these centers are maintained in some capacity. Therefore, it is recommended that in light of increasing budget cuts and impending facility reductions, that priority be given to clarifying and appropriate and continued role of these community-based clinics and that budget appropriations be held to 1986 levels.

4. Community Health Representatives: Since 1969, the CHR program has provided viable and necessary health services to the pueblos. Threats to discontinue funding of this program was a primary concern of the advisory board. Many people apparently do not realize what a critical role this program has had in providing broad community health services and education. The program is particularly important to the elderly for providing transportation to the clinic and hospital and once there acting as interpretor and advocate. Many of the pueblos elders do not speak English well and can not understand the hospital procedures and thus would be nearly helpless without this assistance. Therefore, it is strongly recommended that there be continued funding of the Community Health Representiative Program.

5. Ambulance Services: This is an essential part of the health service system in emergencies situations which is presently very weak or non-existent among the Eight Northern Pueblos. We receive funds to purchase ambulances in past years but can not know secure adequate funds to operate them in a dependable manner. Therefore, it is recommended that IHS lead an evaluation of ambulance services within each of the Eight Northern Pueblos and develop a plan for improving them.

6. Pre-mature Discharges: A recurring comment on the Indian Hospitals is that elderly folks are often discharged before they are fully recovered and that this has had a very negative impact on their recovery to full health. Therefore, it is recommended that this practice be investigated and measures taken to assure that patients should not be released until fully recovered or that frequent follow-up for out-patient care will become a means of assure full recovery.

These comments and recommendations reflect the most pressing health issues of our elderly at this time. I would like to note that these points were presented to Dr. Everette Rhodes, Director of the Indian Health Service, in June of this year. We made a particular point of making specific recommendations and requested a response to each one. To our disappointment, we received a one page response which did not address any of our questions and vaguly deferred the matter to the Albuquerque Area IHS Director. In follow up with him, we found he had received no direction to respond to our questions and recommendations. Incidents like this seriously shake the Tribes' confidence in IHS's sincerety in listening to our needs.

Senator **Bingaman**. Thank you very much, Mr. Hena. I appreciate that.

What I am going to do is to ask a few questions of the whole panel after we complete all the four witnesses.

Mr. Tso, would you go right ahead and give the perspective of the Navajo Tribe.

STATEMENT OF RON TSO, WINDOW ROCK, AZ, ACTING DEPUTY DIRECTOR, DIVISION OF HEALTH IMPROVEMENT SERVICES, NAVAJO NATION

Mr. Tso. Good morning, Senator Bingaman, members of the Special Committee on the Elderly. My name is Ron Tso. I'm acting deputy director of the Navajo Tribe's Division of Health Improvement Services. On behalf of Chairman Peterson Zak and the Navajo Tribal Council, I would like to thank Senator Bingaman for scheduling this special hearing on elderly health care.

I also would like to acknowledge several gentlemen that are with me today. Mr. Kenneth Cody, who is our chairman of our Navajo Council on Aging. Please stand. Also Mr. Richard Bowman, who is our department director for aging services for our Division of Health Improvement Services.

Senator **Bingaman**. Thank you for being here. We appreciate it.

Mr. Tso. I'm here today, Senator Bingaman, to describe to you the complex state of affairs among our Navajo elderly. I hope also to shed some light, discuss currently the tribe's position on these issues. I also hope to recommend some possible solutions. We've also submitted written text in detail for the committee's review. So at this time I will briefly summarize some points of interest.

First of all, I would like to say that I'm happy to be here representing our Navajo people. For I am a young person and I feel honored to be here to speak on behalf of my tribe of our elderly people. I'd like to say our elderly people play an important role in our culture, in our tradition. That they are instrumental in carrying forward those teachings to our young people and certainly provide the valuable guidance particularly in health promotion and disease prevention. I think they have a lot to contribute in that fashion.

It's clear, Senator, that the statistics are real. The problems are there. Yes, we do face many health problems among our people, particularly our elderly. Problems in diabetes, problems in accidents, problems in respiratory disorders, problems with abuse and neglect, problems with inadequate access to health care, problems with home care service delivery, problems with the electricity and problems with inadequate plumbing and heating. There are many that I have not described. I just want to take that moment to reaffirm that those problems do exist. These are also compounded by the fact that our elderly live in increasingly helplessness, in outright loneliness, and depression, which results in their failing health.

I'd like to spend some time, Senator Bingaman, to describe the following tribal efforts on how the Navajo Nation is addressing the needs of these issues. The Navajo Tribal Division of the Health and Improvement Services administers 10 different programs funded by a variety of sources, Federal, State and tribal general funds. We operate a senior citizen program in 43 sites on Navajo lands. We have a foster grandparent program that provides a productive role for elderly volunteers to serve as role models for our young children. We have three elderly group homes, each in the States of New Mexico, Arizona, and Utah. We have a community health nursing program, which is providing direct clinical patient care services at home. The Community Health Representative Program also is available but continuously is fighting for their programs' survival.

I want to make this known, Senator Bingaman, we ask you to continue to support the CHR Program.

We have a food distribution program that provides supplemental commodity foods to Navajo elderly. We have a supplementary payment program from the State of Arizona that provides home-base support services. We have the Indian District Development of Arizona which provides assistance to the elderly in cooperation with the CHR Program. We also have our own Navajo Home Health Agency that provides in-home care, acute skill nursing services.

There are many other services that are provided by our tribe from other agencies, tribal and Federal. Today, you will be hearing from a representative from the Navajo Lands Nursing Home, Inc.

Senator Bingaman, we're aware of problems. The problems of service delivery, problems of duplication, problems of fragmentation, the problems of access to services. I'd like to share with you our proposal as a nation. First of all, we are mandated by a Navajo Health Systems Agency master health plan, also Navajo Nation Aging Program plan, to provide a network of regional multipurpose centers which attempts to localize and coordinate services at each local level. We are charged with responsibility of developing a client tracking system. We also are the focal point for advocacy and intervention to prevent neglect and exploitation of our elderly people. We also are involved in planning, looking at issues of custodial care, residential adult nursing home care, and also to advocate on behalf of the needs of our people.

What we're proposing, Senator Bingaman, is that the Navajo Nation develop a regional network of multipurpose care facilities which receive funding directly from the Federal Government. These regions that we propose will be divided into five local agencies on Navajo which are further subdivided into the chapter communities which are the basic geographically based units of political representation on the Navajo Reservation. It's important to note that the Navajo Nation is unique in that it is a Tri-State Area Agency on Aging. Arizona has been delegated or designated the lead agency.

In order to consolidate these existing programs under a decentralized tribal infrastructure, we want to maximize local services and to improve services out to these local agencies. Some of the services that we envision at each chapter include basic custodial care and ambulatory care. More senior citizen centers that provide nutritious meals to the elderly. It's important to note that the Navajo Tribe funds approximately over 50 percent of these programs. We have a 50-percent unmet need.

We want to include also community level of education and health promotion and disease prevention. I would like to also shed some light on some of the obstacles that we feel may hinder the progress we feel that the Navajo Nation is moving toward. Yes, we are in an era in which there is limited funding. We are geographically residing in areas of high isolation. We've also experienced insensitivity of State and Federal agencies in delivering these services. The lack of a developed infrastructure and isolation combined with low funding produce the situation which our elderly see services on an irregular basis in clinics in which they have difficulty reaching.

Further, limited funding has made it difficult to make expenditures necessary to improve environmental health and sanitation requirements necessary to meet compliance standards. State and Federal rules and regulations need to be clarified in regard to Indian health care, particularly the elderly population. That is why it is important that you closely review those comments by Indian tribes in particularly to the reauthorization of the Older Americans Act. It's extremely important that these concerns be addressed.

We are also facing the dilemma of a possibility of a consolidation title VI and title III funding. So, again, I ask you to carefully look at those concerns brought forth by Indian tribes, particularly the Navajo Nation.

Last I want to mention that the BIA district should make greater efforts to support the establishment of more nursing homes on reservations. As I mentioned, Senator Bingaman, the Navajo Reservation has been designated as a Tri-State Agency on Aging and Arizona has been designated the lead State. In order for the things I have covered for a more decentralized approach to service delivery, it's important that the States acknowledge that equitable funds must be obtained from the State of New Mexico, from the States of Utah and Arizona. And that also they keep in perspective that the Navajo Nation is located on three States.

In conclusion, Senator Bingaman, the Navajo Nation is committed, and as I have mentioned is supporting 50 percent of those services through tribal general revenues. These contributions are made in order that our senior citizens do not fall within the cracks of this multiplex service system. So it is clear our comitment is there.

I would like to conclude by offering the following recommendations. One, that title VI grant moneys now shared by 250 different tribes should be increased. We're seeing a dwindling of funds every year of title VI. And that there should also be a better means of equitable distribution to Indian tribes.

Second, that title III moneys be disbursed through direct funding to the Indian tribes. Presently title VI is directly funded to Indian tribes. We deal directly with States on the title III. We also ask that increased congressional attention should be given to facility construction, program implementation for on-reservation nursing homes and other extensive care facilities, which are presently contracted to off-reservation border towns. We ask that funding be strengthened to the existing reservation in-home service programs. We ask that funding be strengthened to productive elderly volunteer and employment programs. We also ask that more attention be given to onsite professional training and education of our Navajo health care providers, as well as health care administrators regarding elderly issues and elderly health care.

We also ask that both the Indian Health Service and Bureau of Indian Affairs provide more technical support and training in fulfilling that trust responsibility, as well as support in their interagency coordination required under Public Law 93-638.

Thank you, Senator Bingaman, for this opportunity to speak today and I hope I will be able to answer the questions you may have.

Senator BINGAMAN. Thank you very much.

[The prepared statement of Mr. Tso follows:]

TESTIMONY PRESENTED BEFORE
THE SENATE SPECIAL COMMITTEE ON AGING:

THE CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS

by

THE DIVISION OF HEALTH IMPROVEMENT SERVICES
Navajo Tribe
Box 1390
Window Rock, Arizona 86515

Santa Fe, New Mexico

September 3, 1986

INTRODUCTION

Mr. Chairman, respected members of the Committee: my name is Ron Tso. I am Acting Deputy Director of the Navajo Tribe's Division of Health Improvement Services. I am here today to describe to you the complex state of affairs among our elderly. I hope also to discuss some of the possible solutions to the problems facing our elderly, and how we can work together to achieve them.

Traditionally, the role of the elder in Navajo society has been an important one. As they recapitulate a life of industry and thought, they have been very important in teaching our children and grandchildren about Navajo life through their knowledge of legends and through their own example. Our children, as they grow, would take care of the aged and respect them for their teachings. Even in more modern times, the elderly have been a source of considerable economic and emotional support for our young as they maintain the livestock herds upon which the latter have been able to rely during times of unemployment and other stressful times. They have thus been the focal point for the redistribution of the many other sources of household income for the Navajo family. Throughout their lives they have looked after younger children and have been an important source of education and continuity for Navajo life in general.

The wealth of ethnographic and statistical study show that the rural traditional Navajo family serves as this economic, emotional and educational support. Our people consider the family and its elderly leaders as the bulwark to adapting to the modern wage-economy upon which an increasing number of us depend.

Health statistics similarly demonstrate that the traditional life led by the elderly, while often harsh, has been a considerable source of strength for them. Navajo elderly over the age of 55 tend to suffer less from degenerative and cardiovascular ailments such as heart disease and diabetes than do those of similar age in the surrounding American population -- and far less than do many of our own young people.

It is not surprising, however, that certain aspects of our changing Navajo life are also highly threatening to the safety and welfare of the elderly. These aspects are brought about by the accelerating economic dependency of Reservation life, compounded by the rural isolation and underdevelopment which has not changed. The Stock Reduction of the 1930's and the more recent macroeconomic development have accelerated drastically the demands for younger Navajos to obtain education and wage work in locations far from their original homes. They have been forced to live in distant towns and cities in nuclear family units which make it increasingly difficult for them to return to their homes often enough to help with transportation, house work, water hauling, grocery shopping, wood collection and the emotional support which any elderly requires.

This deteriorating kinship support, coupled with lack of telephones, electricity, running water, and fuel for heating and cooking; and substandard housing, roads and access to health, compound the increased dependency of the elderly on non-pastoral resources. As the elderly become increasingly infirm, they no longer have younger relatives about who can maintain basic household cleanliness, nutrition, and other daily social and emotional support. The result is an increasing number of elderly who live lives of increasing helplessness, outright loneliness, depression and failing health, and with the traditional means of support eroding drastically. No alternate means of support have taken the place of these traditional ones.

Thus, when we discuss numbers on the shortage of care for the elderly, we should keep in mind the fact that the difficulties impacting the elderly are often magnifications of those which are affecting Navajo people as a whole.

TRIBAL EFFORTS TO ADDRESS THE NEEDS OF THE ELDERLY

As Administered Through
The Navajo Tribal Division of Health Improvement Services

The Navajo Tribal Division of Health Improvement services administers 10 different programs, funded from a variety of federal and state sources. These include:

1. *Senior Citizens Centers*: Situated in 43 different chapters throughout the Navajo Reservation, these centers provide meals, recreational activities, social services, transportation, and serve as the means of assessing other elderly needs at the local chapter level.
2. *Foster Grandparents' Programs*. This program provides a productive role for the elderly volunteers who serve as parental role models in schools and other institutions serving children throughout the Reservation.
3. *Elderly Group Homes*: These are located in Aneth, Utah; Greasewood, Arizona; and Shiprock, New Mexico, to provide basic caretaking to the elderly on a protracted, non-permanent basis.
4. *Community Health Nursing Program*: Registered nurses provide direct community health nursing/medical services in the homes of the elderly.
5. *Community Health Representatives*: Trained allied health workers provide a wide range of services, including (a) assistance to the Community Health Nursing Program, (b) emergency medical services and transportation on an emergency basis only, (c) community health education, and (d) screening and field diagnostic services;
6. *Food Distribution Program*: This program distributes a range of food

commodities to the Navajo people.

7. Supplemental Payment Program (state of Arizona only): This program augments home based support services for the elderly.
8. Senior Companion Program: Elderly serve as volunteers to work for other elderly in delivering meals to homebound elderly and assisting them with necessary household chores.
9. Indian District Development of Arizona, which provides assistance to the elderly in cooperation with the Community Health Representatives Program.
10. Home Health Agency: This system provides acute skilled nursing care of Navajo Elderly.

Among other services administered by Tribal and Federal agencies are:

-- The Division of Social Welfare which operates a wide range of in-home care and case management services.

-- The Bureau of Indian Affairs which funds off-Reservation nursing homes under contract.

-- The Indian Health Service, which provides clinical geriatric care and community health nursing programs.

-- Private Nursing Homes in Chinle and Toyei which offer skilled nursing and custodial care.

THE TRIBAL DIVISION OF HEALTH IMPROVEMENT PROPOSAL

The Navajo Tribe follows the mandates of the Navajo Health System Agency (NHSA) Master Health Plan and the Navajo Nation Aging Program Plan for a network of regional, multipurpose centers which attempts to:

1. coordinate effectively the multiplicity of services directed toward the elderly
2. establish a comprehensive client referral, tracking and screening

system which would insure that elderly are identified by need

3. coordinate these services are to be as closely as possible with existing family and community support systems
4. serve as a focal point of advocacy and intervention which would prevent the neglect and exploitation of the elderly
5. Maximize opportunities for employment and volunteerism for the elderly
6. Coordinate at all levels other community support services
7. Increase the support of intermediate group custodial support (i.e. group home programs)
8. Increase the support of Residential Adult Custodial Care (i.e. personal-intermediate care systems
9. Increase the support of on-Reservation Residential Skilled Care (i.e. nursing homes)

The Tribe, through its Division of Health Improvement Navajo Aging Services Department, achieves these by becoming the focal point which will insure that the elderly have the appropriate care made available to them, as well as alternatives to the overuse of potentially alienating institutionalization. In the past, this institutionalization has often been the only recourse of the elderly throughout the United States.

The Navajo Nation thus proposes a comprehensive program for the elderly which would revolve around a regional network of multipurpose care facilities, which would receive funding directly (as opposed to a pass through to the states) and would consolidate existing programs. The regions here are divided by the five major Navajo agencies, which are then further subdivided into the Chapter communities, which are the basic geographically-based units of political representation on the Navajo Reservation.

At each of the chapters we propose to support directly and coordinate

1. Basic/custodial care, including basic sanitation, nutrition, mental health counseling, Community Health Representatives, and Community Health Nursing services
2. Ambulatory Care, to include diagnostic screening, health education and other field-based services in coordination with those provided by medical centers
3. Senior Citizen Centers for providing nutritious meals to elderly and assisting them with social and recreational services ties, providing recreational activities, etc.
4. Community-level education in health promotion and consumer protection
5. Employment and Volunteer opportunity programs

At each of the five agencies, we propose

1. ome Health skilled nursing/medical services, including therapeutic treatments and procedures, physical therapy, occupational therapy and speech therapy, as well as other services generally provided by Registered Nurses, under the plan of treatment of physicians
2. Elderly group homes, providing extensive health care and therapy on a prolonged, but not permanent, basis
3. Nursing homes, providing intensive health care and therapy (i.e. skilled nursing care) for the eldelry who require constant and permanent supervision
4. legal ombudsman/advocacy services to protect the rights of the elderly.

At the Tribal/Area Level we propose a primarily decentralized administrative system which includes:

1. compiling data required for planning

2. long-range planning;
3. development of programs in accordance with these long-range plans;
4. negotiation with state, federal and private funding sources for program development, expansion and improvement;
5. evaluation and monitoring procedures which would facilitate staff certification, program accreditation, state licensure, and maintaining and upgrading all rules and regulations competitively with the best in existence for state and federal regulations;
6. launching field based training and education programs which would professionalize our staff in both administration and certifiable health care experience; and
7. negotiating a consistent plan for regular and frequent client referral, screening and identification.

All these efforts are part of the Division of Health's own decentralization-/regionalization, which was mandated by the Chairman of the Navajo Tribal Council, and further mandated by the conditions we have encountered. We see this decentralization of services and planning as the only means for efficient, cost-effective program development.

Obstacles to Strengthening Health Care for the Elderly

There is presently a vicious cycle of limited funding, isolation, lack of a developed infrastructure and insensitive state and federal structures which present obstacles towards strengthening service delivery to and for the Navajo elderly.

Isolation and the lack of a developed infrastructure aggravate the effects of limited funding experienced by these programs. For example, the more isolated senior citizen centers often find that they must make emergency food purchases at nearby trading posts, which traditionally have higher costs, rather than at more distant but more economical stores.

This lack of an infrastructure and isolation, combined with low funding, produces situations in which our elderly receive services on an irregular basis in clinics to which they have difficulty reaching. Their state of health deteriorates, on the one hand, and the cost of direct medical services increases, on the other, as more intensive treatment is often required.

Further, limited funding has made it difficult to make the expenditures necessary to improve environmental health and sanitation requiremeents necessary to meet compliance standards.

State and federal rules and regulations need to be clarified in regard to Indian health care, particularly for the elderly population. For example, the Home Health Agency requested a procedual waiver from the State of New Mexico, so that Home Health Agency could receive reimbursement for treating Medicaid-eligible Navajo elderly residing outside of New Mexico's state boundaries, but within the boundaries of the Navajo Nation and the Indian Health Service Unit boundaries. The waiver was denied because the State of New Mexico requires that out-of-state Home Health Care Agencies have a subunit located in the State of New Mexico, and the professional skilled care providers meet state licensure and certification regulations. This denial does not take into consideration the fact that the Navajo Nation's Reservation boundaries extend across four state lines, and that health care services for the Navajo people do not stop at defined state lines.

The BIA and IHS should make greater effort to support the establishment of more nursing homes on-Reservation, rather than those in off-Reservation bordertowns and distant metropolitan centers. Through this support, we could stem the flow of elderly to off-Reservation nursing homes, where they cannot be visited by their relatives, and where they face an early death in loneliness and despair.

The Navajo Resrvation has been designated as a Tri State Area Agency on Aging, and Arizona has been designated as the "lead state." In order for this arrangement to function equitably, the states must acknowledge that:

1. Equitable funds must be obtained from the states of New Mexico and Utah, as well as Arizona
2. The Navajo Nation is located in three different states
3. The dominant role of the Tri-State Area Agency is as a provider of direct services, as opposed to being a major administrator and conduit of subcontracts.

CONCLUSION

The Navajo Nation has demonstrated its commitment and support for its elderly, by providing over 50% of the support from the Tribal General Fund towards local level elderly programs. These contributions are made in order that many senior citizens do not "fall between the cracks" of our multiplex service system. The Navajo Nation's commitment is clear. Perhaps state and federal officials have not seen the effects of this commitment because they do not understand the conditions under which we, as Navajos, have to operate, and the social changes with which we are dealing.

We, in the Division of Health Improvement Services, thus conclude with the following recommendations;

1. Title VI, the grant monies now shared by 250 different eligible Indian tribes, should be increased from the present $7.2 million to $25 million
2. Both Title VI and Title III monies should be disbursed through direct funding to the Indian tribes directly, rather than through

the states, in order to achieve badly-needed multi-level program coordination

3. Increased Congressional attention should be given to facilities construction and program implementation for on-Reservation nursing homes and other extensive care facilities which are presently contracted to off-Reservation bordertown and more distant metropolitan centers
4. Funding for the strengthening of existing on-reservation and in-home programs should be given high priority
5. Funding for the strengthening of productive elderly volunteer- and employment programs should be given high priority
6. New programs should be developed legal advocacy, consumer protection, and elderly day care
7. More attention must be given to the on-site professional training and education of Navajo health care providers as well as health care administrators
8. Both the Indian Health Service and the Bureau of Indian Affairs must provide more of the technical support and training, as well as support in interagency coordination, required as part of PL 93-638

The intent of the Navajo nation is to implement a plan which will confer as much support as possible to local communities and effect program coordination from the bottom up, as well as the top down. The Navajo Nation would thus continue in its role as developer, facilitator, evaluator, educator and planner.

Thank you for the opportunity to speak before you today, and hope that I have been able to get across as dispassionately as possible a state of affairs among our elderly which has been an anguish among our people.

Senator **Bingaman**. As you can all see Congressman Richardson is here to participate in the hearing. We greatly appreciate that. I've asked him to defer until we complete this panel. We have one more witness in this panel and that is Evelyn Breuninger. She is the secretary of the Mescalero Apache Tribal Council. If you could go ahead and give us your testimony, and then Congressman Richardson will follow with an opening statement, and then we may both have some questions of the panel.

Please go ahead.

STATEMENT OF EVELYN BREUNINGER, MESCALERO, NM, SECRETARY, MESCALERO APACHE TRIBAL COUNCIL

Ms. **Breuninger**. First of all, I'd like to introduce Mrs. Narcissus Gayen. She is the only other person here from the Mescalero, beside Wendall Chino, and myself. Narcissus, would you stand, please.

Senator **Bingaman**. Thank you for being here.

Ms. **Breuninger**. We did have many of our older people that were interested in coming to this hearing, but because of the distance, mainly, it's quite difficult to bring a large group. So seeing the rest of the older people here I think will take care of who we didn't bring. I want to say I'm glad to see so many older people here to listen to what is going to be said.

Someone in Mescalero said, "No good listeners any more," which is true. When the old people get to the age of 60, 65 or on up, it seems as though people ignore them. Even they hate to touch these people. They just resent their being there. And one old lady said maybe I want to go here, maybe I want to go there. But people just are too busy. They're just going at things in a fast way that they are ignoring me.

So these are the people that we're talking about today. And I said, "No good listeners any more" was said by an individual. I'm glad that Senator Bingaman and his staff and other people are here and the gentleman that spoke first, have done what they have done in the past and now. And I have already submitted my written testimony, but I want to stress a few of the points.

One of the items is—the Senator mentioned that in his publication that this would be some sort of planning, a long range planning, to be formalized. What I want to say is that in the testimony or the presentation that I made, this includes our present needs plus items to be included in the long range planning. We have people that are coming of the old—or the elderly age group and we would like to have them included in this long range planning as they come along in meeting the age criteria. In Mescalero, because of the remoteness of the area, we also do take care of other older people in the community, such as people who work for the Government, such as the fish hatchery, the Bureau of Indian Affairs, and Public Health Service.

One of the main items that we need in Mescalero, of course, besides financial, is a building facility. We feel that a building facility large enough to take care of all of the needs of our elderly people would meet most all of their needs as far as comfort, nutrition, and so forth.

And also because of our remoteness, the location of Mescalero, we do need additional transportation. The local Public Health Service has been so drastically cut financially that presently they are contracting with Ruidoso Hondo Valley Hospital, which is located about 19 miles from the reservation; and the elderly, if they are in need of emergency care or dental care or any of the other health care, they have to be transported approximately 26 miles.

And our CHR Program has also been cut so drastically that they are short of vehicles, and the only other service that we have is the title VI program which has a staff of three at the elderly center—a small elderly center. And there is only one van that hauls these people around to take care of all their needs. What I mean is like people have to go to grocery stores or maybe to Alamogordo or Tularosa. Maybe to go do some shopping or maybe take care of medical needs and these are not available.

And also upon talking with other people that are involved in the health care of our elderly, we see a statewide Indian health coordinator as a vital need for the elderly in the State. We are located in such an area that we are quite a distance away from the rest of the New Mexico tribes. And we are not often at hand or close by to the problem at hand when it is discussed, and we are not involved and we are denied our—we are not included in some of the services that do exist. So we feel that a statewide Indian health coordinator be made available, not only to Mescalero, but to all the Indian tribes in New Mexico.

As I said before, I have already outlined some of the personnel that we will need. A health educator, a social worker, and activities director, and so on, for our facility that we are requesting. And being that we have to cut this short, I want to say that times have really changed for our Apache elders. They have really drastically changed for our elders.

Like I said, this is a fast-moving and ever-changing world. And these old people have a difficult time trying to fit into what is happening right now. And whatever we can do in the way of promoting the Apache culture, the pueblo culture, whatever, I think would be a tremendous move in helping our elders so that there would be something to keep them going for their last years of life.

I think that's all I'm going to say right now.

[The prepared statement of Ms. Breuninger follows:]

ADDRESSING THE SENATE SPECIAL COMMITTEE ON AGING

By Evelyn Breuninger, Secretary
Mescalero Tribal Council
Mescalero Apache Tribe, New Mexico

Your honor, the Committee, on behalf of the Aging and the Elderly of the Mescalero Apache Tribe, and on behalf of the Mescalero Apache Tribal Council, I present to you the following which represents an overall picture of our immediate needs and other needs to be included in a long-range planning for our people.

We are including Tribal members and community residents who are in the 55-60, 60-65, and 65 and over age groups. In the foreseable future, our contention is that all of these individuals will benefit from whatever long-range planning is formulazed as our plans are to include them, for a voice in these plans. It will be their plan, a plan that they will adjust or revise to their own needs and satisfaction.

No. 1: Building Facility

This is our greatest need. A building located near the hospital and on the reservation easily accessible for clients. A facility which can provide ample space for nursing home care with at least six beds or more; a day care room; a place for recreation and physical exercise; a place for learning and education in the various fields that affect their daily lives; a comfortable space for relaxing, receiving visitors, to view television, to entertain guests, and provide contact with own age group; a large kitchen and storage space; a large dining area where they may on special occasions, have visitors for meals; a crafts room where they may continue their natuve talents and perhaps have items to seel (projects to motivate and promote self-image, pride and independance); a large laundry room for washing clothes, drying, and mending; ample office spaces for personnel of the Center. All of the foregoing would be flexible to include other needs such as ample storage space for the residents of the Center to store their personal belongings (this is amust from past experiences). An enclosed patio or a large, sunny porch would add immensely to the comfort and enjoyment of the residents.

No. 2: Transportation

This is a must item. Presently their transportation consists of one van. I do not need to emphasize the great need because the needs of the elderly in a remote area such as ours are numerous and detailed. These needs include visits to the doctor, dentist, the grocery store, business calls to nearby towns or in the immediate area, trips to the post office, trips for deliveryying mealsp trips for delivery of medications, trips to other towns or cities for medical attention or recreation. Vehicles designated for the elderly would specifically be used by them or for them so that delays would be avoided and their needs are met more efficiently.

No. 3: Personnel

A. A State-wide Indian Health Coordinator is seen as a vital need for the elderly. Mescalero would greatly benefit from such services. Since Mescalero is located away from the majority of New Mexico tribes, we are often forgotten or simply ignored because we are not near the problems at hand. Services from other areas, not presently known or used, would be made available to ease present problems.

B. Health Educator. This position is seen as a much-needed service. Services would include among many, intrepretation of medicines prescribed, instruction on dental and denture care and related subjects (this has beena neglected field and is much needed); instruction on eye care, prescription glasses and related subjects; education on personal hygiene and cleanliness; Eucation and emphasis on diet and nutrition as there are many disbetics and chronically ill; education on hearing aids; and health education generally on the many subject needs of the elderly. Also, assist in understanding adverse reactions of medications.

C. Health Social Worker. A person they can turn to, to discuss problems and who would follow through and act as mediator in solving these needs. This individual would also act as coordinator of services from other sources. Medical appointnents would be handled by this person and transportation arranged. This person to act as mediator between elderly and families, to arrange for visits by relatives and the younger people. The elderly are pushed aside. No good or attentive listeners any more. Contact and understanding is lacking in many families. In many cases physical and mental abuse exists. The care feeling does not exist. The elderly are buying love by meeting demands for money, gas and material things by their own relatives. The care feeling no longer exists. This individual also to handle finances, help in budgeting, and purchasing. Also to facilitate and handle legal documents. Mechanisims that deal with understanding the elderly needs to be stressed and implemented. This individual would contribute tremendously toward this program because the needs are numerous to list at this time.

D. Physical Educator. Someone there to provide exercises on a regular basis, perhaps toward patticipation in the olympics held for the elderly. Exercises would include swimming, bowling, hiking or walking, sitting or standing exercises. This individual would coordinate all of the recreational activities and the many projects the elderly might be involved in. This individual can offer inst5ruction in handicrafts)crafts with long=term benefits, such as quilting, crocheting, knitting, and others). Long term projects to motivate and promote their privacy and independance. Apache culture and language would be included. Apache crafts would be a tremendous addition. This person to encourage continuation of the various phases of Apache culture, encouraging the elderly to teach the younger generation. This person to encourage and arrange for their participation in headstart, day care for the young, and generally for the young and to act as grandparent figures.

FORWARD;

We want to emphasize that our needs are critical especially with the many services being eliminated or drastically cut due to government budget cuts. Our number one need is financail if we are to provide the needs which are so great as outlined in the foregoing.

Many of our aged refuse to enter nursing home care centers off the reservation because of many varied reasons. The threat of entering a nusring home becomes overwhelming. Many are willing to enter a nursing home if the home is located here on the reservation. Some who direly need this care have returned home and are struggling along with limited services now available.

In some areas, even secretaries are being utilized to provide limited personal services such as laundering, hygiene, home/health care, transporting, and many, many other services. The working hours of these personnel are limited and receive no additional compensation.

Fund rasing projects are undertaken but very limited due to the remoteness of Mescalero and manpower of the elderly is limited.

FINALLY AND IN CONCLUSION:

Times have changed drastically for our Apache elders. It is difficult for them to aacept the fast=changing world which has affected them and more so, their immediate families and the Tribe generally. Fitting into this new and complicated life is laborous, while they are doing their utmost to cling to the Apache way of life. When placed in care centers they have totally fallen apart, having to spend their remaining years in unfamiliar surroundings and strange people trying to understand their exact needs.

We cannot continue in this manner if we are comfort and ease things for the very people who gave us companionship and love. Their depression, lonliness, and their abuse hits all of us and we join others in eliminating this and strive to make their remaining years bearable.

Happy, free, and contented that is our aim with the help and assistance from people such as your Committee.

Senator **Bingaman**. Thank you very much. I appreciate your testimony.

At this point, let me once again thank Congressman Richardson for being here and tell everybody that Bill Richardson and I have been working on these issues and problems since we've been in the Congress. He has had a strong record of advocacy for the programs that are being discussed today, and adequate funding for those programs. Of course, many of the Indian citizens in this State are in the district that Bill represents. So I appreciate very much his interest in this particular hearing and willingness to come by today. He's going to make a short opening statement, then we'll do some questions. So, Bill, thank you for being present.

STATEMENT OF CONGRESSMAN WILLIAM B. RICHARDSON

Representative **Richardson**. Thank you, Senator Bingaman, I appreciate the courtesy you have given me in allowing me to participate in this Senate hearing. This is a very important hearing on health care for the Indian elderly. And once again, Senator Bingaman, I think the initiatives that you have introduced in the Congress, which we have approved in the House, relating to the health care needs of the Indian elderly are to be commended. I think that you are a pioneer on this issue and it's something that I think needs prompt attention by the U.S. Congress.

I also understand that this is a historic occasion in that it's the first Senate hearing ever held on the issue of health care for the Indian elderly. We're breaking ground.

As I think we've heard, Indian seniors are underserved populations on at least two fronts. First, the status of health care in the general Indian population is recognized as being below the national norm. And second, Indian elderly constitute only a small fraction of the total Indian population. As we strive to meet growing needs with declining Federal dollars, we must take special care to ensure that the needs of special populations are met. The problems of the Indian elderly have been a hidden problem. Indian elders are a precious resource. They're culturally revered and should play a significant role in every local community fortunate to have them living there.

Indian seniors, however, are not always able to contribute their all to the people around them. There are no adequate facilities to address their needs. Long-term care facilities are either nonexistent or woefully inadequate on reservations and the Federal agencies mandated to provide services to Indians have no comprehensive long-term health policies. They also don't have the adequate funding in fairness to them. Even with many committed bureaucrats in the Indian health care system, but without adequate resources and adequate long-term health policy planning it's difficult to pursue initiatives that are going to address these problems. These problems include lack of transportation to get to the health care facilities. This becomes a major obstacle to adequate health care for the Indian elderly. Vital programs are under siege in the Congress of the United States. This has been mentioned by some of the witnesses. Community Health Care Programs vital to the provision of care for Indian elderly are constantly under attack by the budget cutters in the administration. The CHR Program, among others, is important for all native Americans, especially in New Mexico. It is one program that I think adequately addresses some of their needs. Once again, though, status of this program is constantly in doubt.

This hearing is significant because it's the first step in identifying specific problems affecting the health status of Indian elders. By holding this hearing here in New Mexico we're getting an opportunity to hear firsthand experiences of Indian elders as well as the problems being faced by care providers. I am encouraged by this strong participation and attendance at this hearing. I'm hopeful we will be able to work out with these agencies, the tribal organizations and Indian elders to see that these vital needs are met.

I want to especially commend many of the representatives who have come from long distances to attend this hearing. The Mescaleros for example. And other representatives of the many rural native Americans that we have in our State. Obviously these concerns need to be met.

Senator Bingaman, thank you for the courtesy that you have shown me in letting me briefly participate in this hearing. I want to commend you.

Senator BINGAMAN. Thank you again for being here and participating. We did issue an invitation to the entire congressional delegation to be here and to participate, and Congressman Richardson was kind enough to make time in his schedule to do that. We appreciate it very much.

Let me just ask one or two questions then maybe Bill would have a question or two, then we need to get on to the other panels. We're already sorely behind in our schedule. We have two additional panels we need to hear from before we break for lunch.

But let me ask Mr. Chavez. In your testimony you indicated a specific problem with the community health representatives being restricted from transporting persons to health care facilities if it's in nonemergency situations. That's what I understood.

Could you tell me how long this Indian Health Service regulation has been in place? And what has the Pueblo done to bring this to the attention of the Indian Health Service?

Mr. CHAVEZ. The CHR Program as I understand in our area is a 638 contract. Whether they're limited in funds or whether they're—they've been told by IHS that they can no longer travel or deliver or transport the elderly people. I believe that's the reason why we're having that particular problem.

Senator BINGAMAN. How long has that policy been in effect?

Mr. CHAVEZ. If I can recollect, probably about 3 years.

Senator BINGAMAN. For about 3 years. But you think there are health care needs of elderly that are going unmet because they cannot be transported back and forth?

Mr. CHAVEZ. Yes, sir.

Senator BINGAMAN. For dental care and health care?

Mr. CHAVEZ. Yes, sir. They really need that transportation.

Senator BINGAMAN. I would just ask if any of the other witnesses have a particular concern about the lack of adequate transportation of the elderly to get the health care services that are otherwise available. Is that a problem in the Navajo Reservation?

Mr. Tso. Yes, Senator Bingaman. We also share that same problem. Based on policies of the Indian Health Service regarding categories which call for transporting clients in nonemergency cases has been discouraged.

Senator **Bingaman**. Let me just ask one other question. Again, maybe Bill will have a question or two.

The criticism that Mr. Hena made about the excess paperwork that is required for community health representatives, is this something that is shared by the other witnesses? Is this a serious problem that we need to try and address? Is there a general consensus that we're putting too much in the way of paperwork requirements on these people, and thereby keeping them from doing what they really ought to be doing? Do any of you have a similar view?

Ms. **Breuninger**. At Mescalero we do. A lot of time is spent on reporting things instead of actually doing what they're supposed to be doing.

Senator **Bingaman**. Is this a complaint, Mr. Hena, that has been brought to the attention of the Indian Health Service as far as you are aware?

Mr. **Hena**. As it concerns the Tesuque Pueblo, yes, I have. I have brought objections of IHS and petitioned whom we deal with. But their answer is that this is being required by OMB and Congress where accountability is the bottom line as far as the response is concerned. But what I am saying is rather than have stacks of forms that they have to fill out, there ought to be some other way of doing the same thing without—I mean it appears like the forms are geared to accounting for every minute of an 8-hour day they're on duty.

Senator **Bingaman**. Bill, do you have any questions?

Representative **Richardson**. Thank you, Senator. Following on that issue, how much of a problem would it be to resolve if, say, the Congress adopted new contracting procedures for self-determination grants to deal with some of the Indian health services that you might be able to pursue? In other words, Mr. Hena, you mentioned the redtape and the bureaucracy. What would be the alternative? Can you show us a path of the Community Health Representative Program going more directly to you or do you want to see a State involvement? Do you want to do it through your all-Indian Pueblo Council? What specifically could we do to eliminate some of this redtape?

Mr. **Hena**. Just speaking for the Tesuque Pueblo, I think we would be more receptive to direct contract relationship with IHS. The problem that arises in that is that we are such a small community. The number of—the amount of dollars allocated to our pueblo is based either on population or land acreage or some magic concept. So the amount of funds that we get are inadequate to do all the things that have to be done. So you have to develop a priority in terms of what they're going to be doing on those contracts. And in terms of the amount of money involved, I recall in 1 year approximately 95 percent of the contract amount went just for salary. And it wasn't very much. But at the same time, because of the inadequacy of these funds, you can't go out and try to recruit highly qualified personnel because they won't come back and work for those kinds of salaries. So it's kind of a built-in choke system in that there are not adequate funds provided on a pueblo-by-pueblo basis.

If you look at it in terms of a cooperative arrangement, even that is hampered, because the same criteria is used. I think historically the Pueblo Indians have been on the short end of the stick because, for instance, the Bureau of Indian Affairs has an agency here in Santa Fe, and they get so many dollars per year to provide the services that the BIA provides to Indian pueblos or any Indian for that matter. But since it provides services to eight different pueblos, its staff, its money and everything else it does is divided in one-eighth. So the pueblos that are involved compete for those services and staff time.

Representative RICHARDSON. Just one last question, and it deals with home health care. Recognizing the differences between the pueblos, for instance, the Navajos, the more urbanized versus rural setting, should there be different standards for home health care? In other words, with the pueblos, doesn't it make more sense because of the smaller number and concentration to develop home health care as the key to any kind of long-term health care for the elderly? And if so, how would we do it? Can we use the volunteer system? I think the issue of Federal dollars is always going to come up. What are some creative ways that we can have, for instance, home health care plans for the pueblos? Is that something that is feasible?

Mr. CHAVEZ. It would be. At Sandia we believe home care is the essential key role as far as the people that are assigned like your RN's and all that. They need to, maybe, realign their programs to meet those needs of the people. They're not reaching them at all. Even if CHR's are there, they're limited as far as doing things that maybe they should be doing. So the RN's—probably have to realign and probably—the basic key is more funding, I think would do the trick.

Representative RICHARDSON. Thank you, Senator.

Senator BINGAMAN. Thank you very much. Why don't we go ahead and dismiss this panel. Thank you again.

Could the next panel please come forward, Dr. Kozoll, Emily Velasquez, and Mary Brueggeman.

Let me indicate that Congressman Richardson has a town meeting in Rio Rancho that he has to leave for, but he will try to return for a portion of the afternoon session.

Let me emphasize two things to the witnesses before we begin this panel. First of all, since we are behind timewise, if you could summarize your testimony, that would be a great help to us. Please try to stick to the 5-minute rule, which we have not been honoring as yet. Also could you please be sure to talk into these microphones so everybody can hear. With that, Dr. Kozoll, please begin. We appreciate you being here.

STATEMENT OF RICHARD KOZOLL, M.D., SANTA FE, NM, HEALTH SERVICES DIVISION, NEW MEXICO HEALTH AND ENVIRONMENTAL DEPARTMENT

Dr. KOZOLL. Thank you, Senator. I am Richard Kozoll of Cuba, NM, and I appreciate the opportunity to present testimony in regard to health care for Indian elders, an area of considerable interest to me. As a physician, I specialize in family and preventive medicine and have practiced 16 years in both the public and private sectors. I have always had the opportunity to provide health services to elderly Indian people in such locations as Pawnee, OK, and Gallup, Santa Fe, and Cuba, NM. I am most familiar with elderly Navajos in the Eastern Navajo chapters of Torreon, Ojo Encino, Negeezi, Huerfano, and Pueblo Pintado, having practiced in the Cuba area for the last 11 years.

Despite my past experience, I remain on the periphery of the problem—and potential solutions—of improving access and quality of health care services to Indian elders. In contrast to my elderly Indian patients, I am a middle income, middle age Anglo raised and well-educated in urban areas of the Midwest. I still struggle with Navajo language and therefore must resign myself to secondhand communication with many of my older Navajo patients. I still find myself sorting out realism from romance when I reflect upon the traditional lifestyle of many elderly Indians to whom I have provided medical treatment. I am, I assume, like you and your committee members, Senator, in that I want to help improve the quality of life for Indian elders while not imposing conflicting values of a different society or my own upon them. This represents a considerable challenge to non-Indian or nonelderly front line medical providers.

Others today will present statistics that describe the inferior health status of many of the Indian elderly resulting from such problems as injury, alcoholism, diabetes, tuberculosis, pneumonia, influenza, and malnutrition. You also have and will hear of the need for greater diversion of Federal financial resources into programs that affect the health status of Indian elders. I will try not to dwell upon these points; I would prefer to make some recommendations based upon personal insights gained from caring for individual patients. Please qualify any comments I make in light of the comments that I have already mentioned.

Let me proceed to discuss a couple of patients that come to mind. I think, for example of C.V., an elderly Navajo lady, from Nageezi, NM, who just died last year at the age of 84. For many of her last 40 years, she suffered with valvular heart disease, a sequella of untreated venereal disease early in her life. Blinded in one eye early in life, she could never accept the risk of surgery for an advancing cataract in the other. I watched her become functionally blind as a result. After the loss of her teeth, similar fears caused her to refuse dentures. Her edentulous state was one factor in the constant struggle to maintain her weight and nutritional status. A more important factor, however, was the level of her New Mexico public assistance support and her total dependence on family members to shop and prepare food for her. You see, she lived alone in a hogan for the 9 years during which she was my patient. As weakness from congestive heart failure, poor nutrition, and disuse atrophy of her muscles became the dominant feature of her condition, she became totally dependent on her family for all activities of daily living. At one point, a Navajo tribal social welfare program provided income to a niece for in-home care and necessary transportation. This arrangement was responsible for considerable medical improvement and social stimulation for a period of almost 1 year at the end of her life. When it abruptly ended, so did her spirit. She was moved to a distant nursing home—there being none in the area where she lived—and she died within another year.

C.V. was fortunate in some respects. She lived within 15 miles of a small satellite clinic at which I and other medical providers were familiar voices. Her medical care was subsidized by the Indian Health Service. She had a responsible and devoted extended family and a little financial help from public assistance. Until her last year, she had her own home, a sharp mind, and a wonderful sense of humor. She did not have transportation, a fully adequate diet, or appropriate housing when unavoidable disability intervened. She did not have sufficient income, and access to adequate chore service, except for the year of in-home assistance. She also did not have culturally appropriate long term care. By the way, the satellite clinic at which she was followed was replaced 1 year ago by a larger outpatient facility 25 miles from her home. When I last spoke to her family, they did not have a relationship with new medical personnel at this more sophisticated but more distant and less personal facility.

S. and H.S., a Navajo couple in their seventies from Ojo Encino, present different problems. Both have an eighth grade education and, until retirement, received regular income from employment. They now have Social Security income, a four-room frame home with all utilities and a pickup truck which H.S. drives. For at least 40 years, however H.S. has had episodes of binge drinking. Despite going through residential treatment on at least two occasions and participating in a local Alcohol Anonymous group, his drinking pattern has been refractory to such conventional approaches. S.S., accustomed during her earlier life to being a caregiver to both her husband and children, experienced sudden role reversal after her first stroke. Predisposed by hypertension and diabetes, poorly controlled during her middle years, the first stroke was but one final event in progressive obstruction of blood flow from atherosclerosis of multiple arteries. My medical efforts after the first stroke have consisted primarily of damage control by regulating her blood pressure, blood sugar, and anticoagulation therapy. Subsequent strokes have caused major disability, and, unlike C.V., her husband's drinking and family situation have left her without needed help at home. She has tried nursing home care on two occasions during winter months, but returned home as a result of loneliness. She is now in a nursing home again, closer to a married daughter, and I do not see her. I do see H.S. occasionally in town or at the office, but he chooses not to discuss his wife.

M.T., a Counselor Navajo lady in her 60's, is dying from cancer of the uterine cervix. She has a supportive family with transportation. She keeps medical appointments, be they at the Counselor satellite clinic (10 miles from home), Cuba (44 miles away), or the Cancer Research and Treatment Center in Albuquerque (125 miles distant). Many other patients in her situation do not have transportation and are not able to keep appointments in this way. Catheters run from her kidneys through her back to a drainage bag as cancer has invaded and blocked her ureters and bladder. Prevention of urinary tract and other infections, followup of her cancer therapies and surveillance for cancer recurrences have characterized my past medical efforts. By virtue of Medicare coverage, she receives home health care. Other Navajo patients—for example, those who have made insufficient Social Security contributions—do not. M.T. does not speak much English and understands the welfare system far better than social services. She receives critical supplemental security income, but the nearest social services (100 miles away) are unknown to her. Her medical care is complex, and cultural and language barriers rarely provide her the opportunity to fully participate in medical decisionmaking. If she could, however, her medical care might still be less than completely satisfactory.

Let me illustrate this last point with a medical vignette. Another patient of mine was reputedly over 100 years old when I saw her in the emergency room several years ago. She had fallen to the ground when a gust of wind blew the door of a pickup on which she was leaning suddenly closed. Her chief complaints upon arrival were chest pain and nausea. An exam and chest x ray films revealed no serious problems and I reassured her through an interpreter that all was all right. As my patient became progressively angry and began gesturing at her upper arm, my interpreter smiled. "She wants a shot," she said. "What for," I naively replied, "the pain or the nausea?" As that was interpreted my patient became even angrier while the interpreter began laughing. "She says you tell her * * * you're the doctor!" It is significant that many traditional healers are authoritarian in their approach. Many Indian elders may be somewhat less than responsive to share medical decisionmaking with their modern practitioner counterparts.

I wish I had time to relate more of these case histories, because I think they illustrate the obstacles faced by those of us on the "front lines" working with the Indian elderly. Let me conclude, then by listing some specific personal recommendations that arise from patient exposures such as those that I have described.

Health care programs that reach elderly Indians should assess problems and develop objectives and strategies at the local level. Every community is different. Local participants should certainly include tribal governments, long-term leaders in various health related disciplines and the elderly themselves. It is hard to imagine how each group at the local level could develop services independent of the other.

Effective programs already operating should have priority for funding. Capricious discontinuation of a needed service, such as the in-home care that I mentioned previously, should be avoided at all costs.

Many Indian communities may benefit as much from better coordination and use of existing resources as new programs for the elderly.

The health care or social service professional with the strongest relationship with an elderly Indian patient or his/her family should serve as the focal point for intervention efforts. Other persons and agencies should respect and support this relationship. There is very little room for turf battles when it comes to caring for the Indian elderly.

Outreach and transportation are critical for many Indian elderly with health problems. Every program or individual patient care plan should develop provisions for these components of health services.

Health care objectives need to be developed for the individual patient, not just the community or the provider. These objectives should include functional goals, disease control parameters, family support and needed outside resources.

Health promotion activities such as weight control, dietary improvement, exercise programs and alteration of the home for safety considerations should be introduced carefully and realistically. Support for such activities by tribes and health authorities should be increased by research and demonstration efforts as well as funding allocation to those programs already proven effective.

Finally, career development of needed health and social service professionals with expertise in caring for Indian elders should be established as a priority.

Senator Bingaman, your leadership in improving health care services for Indian people is both timely and important. I and other practicing health professionals stand ready to assist you in your effort in any way possible. Thank you again for the opportunity to share my views, and I look forward to answering questions at the end of the panel.

Senator **BINGAMAN**. Thank you very much, Doctor.

Our next witness is Emily Velasquez. She is the director of the Title VI Program at Isleta Pueblo. She also serves as the president of the Title VI Coalition.

Ms. **VELASQUEZ**. San Felipe.

Senator **BINGAMAN**. San Felipe, excuse me.

Ms. **VELASQUEZ**. I was down there. I left that.

Senator **BINGAMAN**. We appreciate you being here. Please go ahead.

STATEMENT OF EMILY VELASQUEZ, SAN FELIPE PUEBLO, NM, DIRECTOR, TITLE VI PROGRAM

Ms. **VELASQUEZ**. This statement is addressed to the Senate Special Committee on Aging. I am Emily Velasquez, president of the New Mexico Title VI Coalition, representing approximately 8,000 Indian elderly of the 19 pueblos of New Mexico and the 2 Apache tribes.

Senator Bingaman, we thank you for giving us the opportunity to present to you our thoughts on issues relevant to the Indian elderly. We commend your staff and the staff members of the Senate Special Committee on Aging for your initiatives, concern, advocacy, and leadership in giving us this forum. In turn we intend to use this vehicle in achieving the notoriety in our efforts to bring attention to the health needs of our Indian elderly.

The needs are many and categorically fall in special areas of concern. Foremost of our concerns is an area most critical to the well-being of our elderly. The nutritional service offered to our Indian elderly must be weighed in terms of how best it benefits them, both in nourishment and the emotional impact it has on them. For example, we all know that proper nutrition is essential to the promotion of good health; however, the additional benefits of bringing the elders to a nutrition site can have an equally positive impact on their health. The elders receive the healthy encouragement of socialization with others; their health can be monitored at the site and certain basic health services can be delivered. They can receive health education and such things as safety and CPR training to enable them to avoid accidents and assist each other in time of need. All these and more are activities which can contribute to their good health, and would be very much in keeping with the intent of Senate bill S. 400, which you have sponsored, Senator Bingaman.

Another piece of legislation which is, of course, related to these issues is the Older Americans Act. Under the act, titles III and VI are designed to provide nutrition and supportive services to the elderly. However, current levels of funding for title VI are not adequate to permit grantees to provide any more than basic nutritional services. Greater coordination between the two titles is needed in order to allow the title VI grantees to provide much-needed supportive services utilizing funds from title III.

In addition, title IV research and development moneys should be made available to title VI grantees in order to allow for the needed training and technical assistance to assure proper program management.

There is a need for concentrated research on the dietary habits of the Indian elderly, whose lifelong diet may drastically contrast to the modern day application which is geared toward non-Indian concept of nutrition. Some studies are readily available that reflect the results of nutritional over-or-under indulgence and produce obesity, diabetes, and other ailments related to nutritional habits. This, then, is an urgent issue that cries for solution so that the longevity of our senior citizens is extended and assured. This issue can be addressed by professionals in the field if, indeed, funding for this research becomes available.

A crucial issue that everyone can agree on is the crippling impact budget cuts have on the total health delivery system for the elderly. This now threatens the very survival of the intent of the furtherance of the concepts of viable Title VI Program operations. Eliminations, minimizations or makeshift coverage is the end result, and threatens the availability of crucial services such as eyeglasses, dentures, hearing aids, and other prosthetic devices needed by the Indian elderly.

The Senate Special Committee on Aging can be instrumental in supporting budget requests, or countering attempts to further diminish the Federal fiduciary responsibility to its first inhabitants of this great land we call America—the aforementioned issues have been addressed many times before in like forums by coalition, tribal councils, and interested concerned groups advocating for desired solutions. Methods and corrective approaches have been suggested by the creation of national policy on Indian aging. This document contains many well thought-out recommendations geared toward the betterment of the Indian elderly. One passage that qualifies the need for a policy or justifies a need for a policy stated "in view of the severity of the needs of Indian and Alaskan Native elders," it is important that clearly delineated guidelines be established. The formulation and documentation of such, throughout the delivery system would help to fill in the gaps in services between agencies, and would be cost-effective in that it would help to avoid duplication of effort. In addition to this effort on the part of agencies and their present patterns of operation, a national policy which identifies the elders as a target or priority group would bring about significant improvements in their well-being.

The agencies which are in place are the Administration on Aging, Administration for Native Americans, Bureau of Indian Affairs, Indian Health Service, and the Department of Housing and Urban Development, as well as the agencies of the State of New Mexico. These agencies must begin to be more purposeful in their asserted desire to help.

The efforts to agree on a national policy on Indian aging must, in our opinion, be reintroduced and discussed. We stand ready to entertain a logical approach to address the needs and concerns of the Nation's Indian elderly.

Senator Bingaman, I would like to thank you for giving me this opportunity to make this testimony to the Senate Special Committee on Aging.

Senator **BINGAMAN**. Thank you very much for your testimony. We appreciate it. Our next panelist is Mary Brueggeman, who is the administrator of the Rehoboth McKinley Christian Home Health Services in Gallup. We appreciate you being here today.

STATEMENT OF MARY L. BRUEGGEMAN, GALLUP, NM, ADMINISTRATOR, REHOBOTH McKINLEY CHRISTIAN HOME HEALTH SERVICES

Ms. **BRUEGGEMAN**. Thank you very much for this opportunity to speak this morning, Senator.

Home health care for Indian elderly has been an issue that has been a very important part of my life for several years. I'm familiar with the level of home health services for the 14 tribes that are served by the Santa Fe Indian Hospital. Also from my number of years in working with the Zuni Indians, I implemented and directed a home health care agency for the Zuni Tribe for 5½ years. We are serving a number of Navajo patients in our Gallup Home Health Care Agency currently. I believe that home health care services is an ideal form of medical care for native Americans.

I believe this because it is very important for native Americans to be at home with their extended families, where their language is spoken and their culture is familiar to them. There are numerous statistics available that when a native American person is institutionalized, either in a hospital and, particularly in a nursing home, that they may actually digress in health due to the alienation or loneliness.

For these reasons I firmly believe that home health care is a vital part of the health care delivery system for native Americans. Unfortunately, currently home health care services are not being delivered to the Indian elderly as they are to the rest of the population. There are a number of reasons for this. There is a fallacy that Indian Health Service community health nurses provide home health care services. They attempt with limited resources to provide a form of home health care, but the emphasis is actually public health services. They're doing immunizations, communicable disease work, newborn followups, well child clinics, diabetic clinics for new diabetics, and they have a very strong public emphasis.

Indian Health Service should be commended for decreasing the level of infant mortality through the community health services and for addressing a lot of the other public health issues. But they are not able to address the home health needs of the Indian elderly. Home health care is often, actually, a very frequent and consistent level of care with several visits, if not daily visits to the patient, for dressing changes, catheter care, and instruction. There are a number of services, such as physical therapy and speech therapy, that are not delivered at all to Indian people in the home. The rest of the population in New Mexico has these services available to them, and also in parts of Arizona for the Navajo patients.

Besides the gap in Indian health service delivery, it is difficult for existing home health agencies to deliver home health services to a number of American Indian patients. Many of our Indian elderly are in rural areas, which are isolated. Consequently the amount of driving time to reach the patient and the amount of time in the visit is longer than it would be for a patient, for instance, in Santa Fe. The visit may also be longer because you may be delivering a service through a translator. And you may need to spend more time with the patient and his or her family to be sure that there is an understanding involved in the medical care that needs to be delivered.

Health Care Financing Administration [HCFA] people who are regulating Medicare and indirectly Medicaid benefits for home health care do not understand longer visits, more driving time. They do not understand the differences in delivering health care through a translator. These issues are not considered in the policies for HCFA.

Another point that needs to be made is that according to HCFA regulations there is a homebound requirement for eligibility for home health services. This homebound requirement may have been pertinent to the person who wrote the regulation which states that the patient may not leave the home without a form of assistance, but they are allowed to attend a barber or hairdresser or a church once a week and still be considered homebound. You can imagine for our elderly Navajo or Zuni patients or any of the other pueblo patients, this interpretation is not pertinent to their lifestyle. Occasionally the families will take an elderly person with them. If they live in a rural area, they may only go to town once a week or once every 2 weeks to shop. Rather than leaving that elderly person at home, they will put them in the pickup truck, or the car, and take them to town. The patient is really homebound and very ill, and will spend the entire day in the vehicle while the family is shopping. But if a home health agency makes a visit and the family and patient are gone, we have to document why the patient was not there. Because of this, HCFA does not find that going to town with the family is an allowable reason not to be home. It seems that because the patient is too ill to be left home alone, would be more acceptable than attending the hairdresser.

Another point that I would like to make is that a requirement for the delivery of home health care is that the patient have a telephone or access to emergency services. This is not possible for the majority of Indian elderly. Most of the home health agencies are delivering services even though there may not be a phone in the home or immediate access to emergency services, but this is a requirement.

Most of the Indian patients for many reasons may not have Medicare or Medicaid coverage. This is a very big issue for existing home health agencies in delivering services to the Indian elderly. Without Medicare or Medicaid coverage, there will be no reimbursement for the home health care agency for delivering the service. Medical care costs are extremely high now, and the home health agency will not be able to make the number of visits needed to provide quality care without reimbursement.

Indian people have relied on the Indian Health Service for their health care. They do not seek private insurance or HMO's as other population members do. Consequently I feel that Indian Health Service has a responsibility to provide home health care to the Indian elderly. I suggest that Indian Health Service pay for the home health care services to existing home health agencies through contract health service dollars. This was achieved in Zuni Pueblo, because we had a number of patients who desperately needed home health care and were not able to receive the care they needed because they did not have Medicare or Medicaid coverage or any other means to pay. After 5 years of negotiating with the Zuni IHS PHS Service Unit, we were able to receive contract health services dollars to provide home health care. This took a lot of energy in negotiating and convincing the service unit director and various persons, such as community health nurses, what the difference is between home health care and community health nursing.

I also think, at this time, as Dr. Kozoll mentioned, it is important to bring to light that there is, so to speak, a turf battle between Indian Health Service employees and tribal health employees. Unfortunately, a majority of Indian Health Service community health nurses, and possibly their administrators, are hesitant to refer Indian elderly patients to private sector home health agencies. We entered into this problem in Zuni, and I'm also experiencing this problem currently with Gallup Indian Medical Center in Gallup, NM, where we're trying to deliver services to Navajo patients; and I have met with great difficulty in getting referrals from the Gallup Indian Medical Center.

In terms of your request as far as improvements that could be made, I feel that there needs to be a regional adjustment through HFCA, or a way to achieve fair reimbursement for agencies that can deliver home health care services to Indian elderly. I think that there are numbers of HFCA regulations which need to be revised to take into account the cultural and language barriers which might exist in delivering services to Indian elderly.

I think that there needs to be funding provided to expand services into the service area to reach the rural and isolated and remote Indian elderly patient. I believe that there should be funds provided to tribes to start their own home health care agencies.

There are a number of barriers which tribal governments encounter in starting their own home health agency, but I do believe that these can be overcome and that was exemplified in Zuni Pueblo.

Just briefly, a few of those barriers are: First of all, money—funding; recruitment and retainment of the director of RN's—professionals; the turf battle with Indian Health Service as far as the tribe providing their own health care; and also, dealing with HFCA regulations. But as I said, these barriers can be overcome.

I do believe that to make improvements in health care, home health care to the Indian elderly, we need to have referrals from the Indian Health Service physicians and Indian Health Service community health nurses. I believe that a mandate from the Indian Health Service's service unit directors will be required for the community health nurses to refer those Indian elderly people that they know need home health care to existing home health care agencies, so the services can be provided. I also believe that there has to be an active Indian Health Service role in certifying all Indian elderly people who are eligible for Medicare and Medicaid to get them onto their payments source. And if not, then we must have contract health service dollars to provide them with home health care.

I also agree with Dr. Kozoll that there needs to be educational funds to train more Indian RN's and also persons need to be provided who would give technical assistance in directing a home health agency at the tribal level.

Again, I thank you for this opportunity and I appreciate any questions you may have.

[The prepared statement of Ms. Brueggeman follows:]

REHOBOTH
McKINLEY
CHRISTIAN HOSPITAL

August 26, 1986

The Honorable Jeff Bingaman
Dennis Chavez Federal Building
Room 9017
500 Gold Avenue S.W.
Albuquerque, New Mexico 87102

Att: Faith Roessel

Dear Senator Bingaman:

Please find enclosed a copy of my written testimony and cover letter sent to your Washington, D.C. address on 8/22/86.

Per your recent request, I am sending you the testimony to your Albuquerque Address and providing you with the following Biographical information:

I have a Masters Degree in Medical Anthropology from Southern Methodist University in Dallas, Texas and specialize in the implementation and delivery of medical services cross-culturally. My Bachelors Degree is in Anthropology from the University of South Florida, Tampa, Florida. My experience with Home Health Care for Indian Elders is listed in my cover letter of 8/22/86.

I have also been very active in the New Mexico State Association for Home Care (NMAHC) and an active supporter of Rural Home Health services for Indian people.

I will need for your office to make the 50 copies needed for the hearing. I am looking forward to joining you in Santa Fe. Again, if I may be of any further assistance, please do not hesitate to call on me.

Very Sincerely Yours,

Mary L. Brueggeman

Mary L. Brueggeman, Administrator
Rehoboth McKinley Christian
Home Health Services

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Continuum of Health Care for Indian Elders

Home Health Care Services

Background Information:

Home Health Services are nursing, aide, physical therapy, speech therapy, occupational therapy and medical social services provided in the patient's home. Due to the recent DRG regulations causing shorter hospital stays, Home Health Services now include high technology in the home such as specialized Pediatric services, full home I.V. services, ventilator services and home dialysis for the appropriate patients.

Federal and State Home Health regulations stipulate the patient must be considered to be homebound and in need of intermittent nursing or therapy care. This regulation is interpreted to mean the patient can not safely leave their home without the assistance of equipment such as a walker, wheelchair, cane or the arm of another person and that the patient require only intermittent nursing ordered by a Physician as opposed to 24 hour/day care. Home Health Services can be delivered to all ages as long as the patient meets the above requirements.

The major advantages to Home Health Care are that it can decrease the number of hospitalizations for patients, it enables many patients to return home sooner following a hospital admission, it enables many patients to avoid institutionalization all together such as hospitalization or in particular, admission to a nursing home, it allows the patient to be with their family during an illness and at home in an environment familiar to them, and last but not least, it is much more cost effective than institutionalization.

I find Home Health Care to be particularly appropriate, or perhaps, ideal for Native American people. The high incidence of diabetes, hypertension, arthritis, and alcohol related problems among Native Americans requires the on-going, noncrisis oriented service home health care can provide. The strong desire of community members, and especially the elderly, to remain at home further warrants the benefits of Home Health Care.

Native Americans are spiritually tied to their home land. Their community, their home, their land, and their family are very important to them. Especially, for the elderly, it is crucial for them to be able to stay in their community where their language is spoken. It is extremely alienating for them to be in a hospital or institution which removes them from their home or family. It is recognized that Native Americans who are institutionalized a distance from their home may often digress in health or require a longer than expected recovery time. In addition, within the extended family structure, there are often heavy guilt repercussions for families who do have to resort to nursing home placement. It is believed that elders who are institutionalized will soon die of alienation.

Furthermore, the elders are a cohesive force in the communities. It is their role to supply much of the cultural, religious, and traditional wisdom to the families.

Therefore, you can see that by allowing ill persons to remain at home, by including the family in the care of the patient, by allowing earlier Hospital discharges,and by preventing hospital or nursing home admissions, Home Health Care is an important part of the health care delivery system for Native American people. I believe it is agreed that the Home Health Care Services facilitate the maintenance of the family, social and cultural traditions of the Indian Communities which receive Home Health Care Services.

Gap in Home Health Services Available to Indian Elders

Although Home Health Services are particularly ideal and desperately needed for Indian Elders, there remains a large gap in the provision of these services to Indian Elders.

There is only one tribally owned Home Health Agency located on an Indian reservation in New Mexico. This is the Zuni Pueblo Home Health Care Agency. Indian Health Service Community Health Nurses and Community Health Representatives attempt to deliver some Home Health Care on other reservations, but are governed by mandates which extremely limit their level of Home Health services and require a Public Health emphasis. There are also some Home Health Agencies in New Mexico (ie: Gallup, Farmington, Albuquerque, Santa Fe) which go on to the surrounding reservations for specific patients. However, these Agencies must deal with several impediments or obstacles making the delivery of service more costly for which they are not reimbursed. Consequently it becomes very expensive to care for many of the Indian patients and the Agency either has to discontinue the care or risk going out of business.

Issues on Gaps in Service - Indian Health Services

Almost all Indian Health Service Community Health Nurses are deliverying Public Health services. They are responsible for such duties as: immunizations, diabetic clinics, well child clinics, new born follow-up visits, infectious disease control, counselling regarding missed appointments and compliance. The Community Health Nurses are responsible for the entire Community. Due to their workload they may be able to make only infrequent visits (usually about once a month) to a patient. It's a little different on every reservation but, generally speaking, the community Health Nurse does not have time to do twice daily dressing changes to one patient: antibiotic I.V. every 8 hours on another patient; assess the status of a patient on Home Oxygen; teach a new diabetic insulin injections, diet, fingersticks; teach parents the use of an apnea monitor for their high risk infant and on and on.

The Community Health Representatives are tribal employees funded by Indian Health Service. C.H.R.'s, as they are more commonly called, are para-professionals most of whom are comparable to the Aide level of training on some reservations. They are responsible for community education in the areas of safety, dental hygiene, family planning; deliverying medication to the patients homes, transporting patients to appointments and assisting the Community Health Nurses with newborn follow-up, etc. On many reservations there is a lack of coordination between the Community Health Nurses and the Community Health Representatives. There remains a large gap in service for those homebound patients requiring intermittent Home Health Services.

None of the Therapies are available in the home through Indian Health Service. For example, a newly diagnosed Cerebular Vascular Accident (Stroke) patient would not receive physical or speech therapy unless the family could transport the patient to an Indian Health Service facility.

Obstacles Which Impede Delivery of Service by Existing Home Health Agencies

There are many HCFA regulations/requirements which make delivery of Home Health Services particularly difficult to the Indian Elders. The Homebound Requirements and interpretation is particularly inappropriate for many of the Indian Elders. It is very common for family members to take an elderly to various religious ceremonies which may last a number of days. Or they may take the elder along for a day in the car or truck on their one day trip to town in two weeks to do their shopping. If the Home Health Agency visits and finds the patient not at home for reasons other than a medical appointment, the patient is not considered to be homebound. However the interpretation in the manual reads.

Another problem is the fact that services for particular diagnoses are expected to be completed within a certain (reasonable and necessary) number of visits. For example Diabetic Teaching . The nurse may have to visit a few more times to achieve the same level of teaching if she is teaching through a translator or if, due to cultural reasons, the patient has difficulty in injecting himself or if the patient eats a traditional diet and does not understand or comply with the diabetic diet. If the Agency visits beyond what

HFCA feels is necessary in other circumstances, the Agency will be denied payment for those visits.

Another problem to consider is that most of the Indian Elder patients live in a rural or isolated area which could often involve inaccessible roads and more importantly long driving distances. It is a known fact that a Home Health nurse must make a minimum of 5-6 reimbursable visits per day in order for the Agency to stay in business. The driving time involved in seeing these patients usually is the equivalent of two to three patient visits. In other words, in the time it takes to drive to see on Indian elder on the reservation, three to four patients could have been seen in town. The Agency only gets reimbursed for the one patient and consequently ends up losing a substantial amount of dollars after paying the nurses salary and mileage.

Frequent inaccessibility due to impassable roads during rain or snow greatly affects the number of visits which can be made. Therefore the HCFA regulation of Supervisory Visits every two weeks is extremly difficult to accomplish in these conditions. An Agency therefore has to discharge the patient, then readmit the patient when accessible creating an inordinate amount of paperwork for the Agency and Physician. In addition, the HCFA requirement that exactly the number of visits the Doctor ordered has to be made each week or, if not, written justification has to appear on numerous forms creating even more difficulties in rural areas.

Due to the lack of electricity or running water at many patients homes, the RN or aide have to haul the water and may even have to build a fire in a wood stove to heat the water for cleaning a wound or bathing a patient. The Agency is not reimbursed for the greater cost of a longer visit required.

Home Health Agencies deliverying services in rural areas have very many extra costs which are not considered in reimbursement to the Agency. All of these obstacles can be dealt with through additional funding for existing Home Health Agencies or by Tribes establishing their own Agencies. Following is an account of the Zuni Home Health Care Agency which is now very successful:

The Pueblo of Zuni Home Health Care Agency

In 1979, the Pueblo of Zuni Health Services Division prepared, submitted and defended a proposal to the federal government for implementation of their own Home Health Care Agency to fill the gap in service delivery.

In 1980, The Pueblo of Zuni received the federal grant from the Department of Health and Human Services to begin a Home Health Care Agency. This grant award of $110,000 was classified as "seed-money" meaning that it was a one time, start up grant which would not be refunded. Within the grant, the federal office stipulated that the Agency must become a licensed and certified Home Health Agency thereby making it eligible to collect Third Party Reimbursements for the services such as Medicare, Medicaid, V.A. Benefits, Private Insurance who offer Home Health Coverage and possibly Railroad Retirement Benefits.

This was a major innovative and progressive step in the history of health care for American Indian people. Number one, the Zunis were to deliver their own health care independent of Indian Health Service delivery system and independent of Indian Health funding. Number 2, the Zunis were to enter the world of Private pay and Third party Reimbursement where they delivered a health service which is not free, but collects fees for its services. Number 3, the Zunis, as owners and operators of their own freestanding Home Health Agency, are able to deliver a Health service to their people which can consider the many cultural and socioeconomic aspects of their lives.

Unique Challenges for a Rural Tribal Home Health Agency

There are many obstacles or challenges which entered into play for the Zuni tribe to take this innovative step. Although the federal government is strongly urging Indian Tribes to fully take over operation of their Programs and Services, (ie: Public Law 93-638, Indian Self Determination), there still remain some opposition to this change among some federal employees. In particular, a problem arises which could be described as somewhat of a Turf Battle. The Indian Health Service Community Health Nurses were concerned about their job responsibilities with the implementation of the Tribal Agency which would handle many of the responsibilities previously assigned to them. Therefore, it was necessary to spend great amounts of time and energy clearly defining the exact role of the Home Health Care Agency RN and that of the IHS Community Health Nurse to insure that there would be no overlap or duplication. The same problem existed with the Community Health Representatives. As a result, the two entities are able to now coordinate services in order to provide a strong comprehensive network of home services to the Zuni Community.

Another challenge to consider is related to the ruralness of our location and that is the difficulty in recruiting and retaining professionals.

In order to recruit professional, licensed providers such as Administrators, Registered Nurses and Therapists to such a rural area we must have competitive salaries and benefits. We have always had to go outside the communities to recruit these personnel because the professional Zunis and Ramah Navajo persons have preferred to seek employment with IHS due to the salaries and outstanding government benefits. I hope, with time and recruitment efforts we will be able to attract local professionals into our Agency. (It is critical that professionals with Home Health experience direct the Agency or it will not succeed).

A number of other challenges which presents an interesting twist, are due to the socio-economic and cultural aspects of the population served. The Zuni Home Health Care Agency has unique problems or situations which are not often encountered by urban Visiting Nurse Services. Home Health Agencies. These challenges definitely have a significant impact on our service delivery. Specifically, these challenges include: number one, the issues of delivering home health care in a rural/isolated area where there may be often inaccessible roads, no running water, no electricity, and little or no availability of foods with high nutritious value such a fresh produce, meats, etc. Number 2, the issues of delivering home health care to patients who speak Zuni or Navajo, very little English or may speak English as a second language. Number 3, the issues of delivering home health care to a population which has two or more medical delivery systems operating in full force at the same time-these being the traditional medical systems of the community, as well as the contemporary or Western Medical System. Number 4, the issues of delivering home health care services to a population which also has many other cultural and/or religious practices which can affect the delivery of the service. The first issue is related to the ruralness or isolation of the Ramah/Pinehill. The frequent inaccessibility of the patients roads means that often nursing visits and aide visits to the patients must be postponed until the road drys. This affects the number of visits that can be made as ordered by the Physician and also the requirements by regulations to make a supervision nursing visit at least once every two weeks. Due to this regulation we often have to discharge patients, then readmit them when we know they will be accessible.

The lack of running water, in many cases, has an affect on the care which can be provided. The Home Health Aides in Ramah/Pinehill carry bottled water with them in order to provide personal care to their patients. The lack of refrigeration affects the storage of perishable foods. There is a higher incidence of diarrhea and stomach discomfort often associated with consumption of spoiling food. In some cases, this has increased the amount of teaching/education required for patients.

The isolation and lack of a well stocked grocery store affects the care of those patients with special diets. Little or no fresh produce and meats increases the teaching/education required regarding nutritious diets. The nurse must be familiar with the traditional diet and nutritional values of traditional foods.

The second issue of delivering home health services to a population with a language different from that of the nurse concerns both the

Zuni and Ramah Navajo communities. If the patient speaks little or no English, an Aide or other employee must accompany the RN for translation. Delivering health care through translation is difficult in itself because one is never really sure what level of understanding is achieved with the patient or the RN and also one wonders what feelings or thoughts may be lost in translation.

It is also a consideration if the patient speaks English as a second language, because there may be still an affect on the level of communication.

We find that often there are many miscommunications between the physician and the patient or patient's family. We believe this is due to basic language differences as well as modes of communication.

The third issue of deliveryingHome Health Services to a population with 2 or more medical systems operating simultaneously also concerns both the Zuni and Ramah/Pinehill communities. 2 or more medical systems working simultaneously determined our philosophy for service in our Agency. The Agency adheres to an holistic approach to Health Care realizing that the health of the entire person including their spiritual being, is of prime importance.

2 or more medical systems operating simultaneously also means our nurses and aides must be flexible or understanding if another healer is called in on the case by the patient or family.

Before Public Health Service entered these communities, the traditional medical system treated all ailments and health related problems. Present in both of these communities is the belief that other people, or another person, has the ability to make you sick or to cause you harm. For those of us who have studied Medical Systems, we realize that belief concerning what caused one's illness is the determining factor in what treatment one seeks to cure the illness.

If one believes a person with power greater than their own can make then sick, then they must seek a person with even greater power to cure them. The traditional healer, or The Medicine Man, is such a person in both the Zuni and Ramah/Pinehill communities. This person is sought when the patients suspects their illness or harm is caused by another person. The curing provided by the Medicine man often involves many more persons then the patient and is quite effective. This treatment is particularly effective for illnesses labeled as "psychosomatic" which the Western Medical System has tried desperately to treat with little success.

In Ramah/Pinehill the Navajo patients also rely on the Medicine Man when they feel he is needed to cure an illness caused by another person. Working at another level within the traditional medical system are herbalists and many who rely on the Native American Church which centers around the medicinal properties of peyote.

I have found that in our Home Health Care Agency, it is most important that our staff do not, in anyway, discourage the use of the traditional healers. The Zuni people and the Ramah Navajo people wish to use both medical systems as needed. They may often use both systems for the same ailment. For example we may treat a stasis ulcer on a lower extremity with betadine, peroxide, and a wet to dry dressing. If the ulcer persists, the patient or family may contact a traditional healer who may apply a salt water solution or perhaps pinon sap, which both have definite healing qualities.

In our Agency, we must also realize that the health of the total person is necessary. We may be able to treat a physical symptom, but with little success if the patient is depressed, lonely, or emotionally upset. Therefore our philosophy of service considers the well being of the whole person, the total needs of the patient. This Philosophy can be stated as "One Heart, One Mind, One Body".

Last, but not least, various cultural, socio-economic, and religious practices have an impact on our delivery of Home Health Services, also. For example, in Zuni during certain times of the year, many of our patients practice an observance called tesque which is considered a time of fasting. This could be anywhere from one to 10 days. During this time, the patient's diet changes, where they do not eat any foods containing animal fats. Also, the patient can not be fully bathed nor can they be exposed or have any contact concerning their genital area. In addition the patient or any member of the family can not discard of any garbage or trash during this time. They also cannot exchange money ie: buy groceries or sell jewelry. This of course, affects the delivery of Home Health Services and is not taken into account by any regulatory body.

Another consideration is the strength of the extended family and also the seasonal housing. For example, the patient may live with one family for a period or time and then change residence to live with another relative. The nurse or aide will then need to locate the new home, which may be temporary. This is a particularly important consideration in Ramah/Pinehill where the seasonal or temporary location is a long distance, 30 miles or so, from the original home. Also, the nurse and aide must then learn who is the new care taker, or responsible person, for this patient. Often times, a whole new set of relatives must be taught about the patient's illness and how to care for the patient. It is usually not possible to be reimbursed for teaching another caretaker.

In Zuni, following the death of a family member, our service is stopped for at least 4 days following the burial. Many Visiting Nurse Services or Home Health Agencies would increase their services at this time for support of the patient and family and also because many patient's health problems exacerbate when there is a death in the family. However, the Zuñi burial traditions require that the family observe 4 days of mourning following the burial of a family member, and it is not appropriate to deliver health care unless it is an emergency.

Another consideration is that, due to our patient's involvement in their Indian religion, often times they are busy at the time of a nursing or aide visit. The Native American's religion is practiced every day and is very much a part of their daily life. In addition, many of the Zuni Indian religious doings may take place at night where the patient could be sleeping during the day at the time of the nursing or aide visit.

Again, I will emphasize the importance in our service delivery of accepting and working within the framework of the culture of Indian Communities.

I would like to point out, at this time, that I am not saying whether these issues affect the delivery of home health services in either a positive or negative way. It would be totally inappropriate to make such a judgement. However, these issues are points of consideration which have an impact on the total delivery of Home Health Services. These issues produce additional costs for deliverying quality services to some Native American Elders for which the Agencies are not reimbursed.

Summary

There is a definite gap in Home Health Services to the Indian Elders for a variety of reasons. Patients are falling through the Indian Health Service cracks; tribes have many obstacles in establishing their own Home Health Agencies and existing Agencies have many obstacles in providing services to Indian Elders in rural areas. Even though Indian Health Services can not provide Home Health Services, the I.H.S. Service units are unwillingly to pay for Home Health Services with Contract Health Services dollars. Only after five years of persistence did the Zuni PHSIHS unit agree to pay for Home Health Services for those Indians residing on the Zuni Reservation with no other third party coverage. However, I firmly believe all of these obstacles can be overcome with appropriate funding for implementing new Tribally owned Home Health Agencies and for deferring costs for existing Agencies already attempting to deliver the service. In addition regulatory changes should be made which consider the unique circumstances involved in deliverying Home Health service to the Indian Elderly.

Senator **Bingaman**. All right, thank you very much for your excellent testimony.

Let me just ask a very general question and open it up to the entire panel for a response.

Could each of you describe to me your impression of the extent and seriousness of how many Indian elderly do not receive adequate health attention? I understand many seniors live in isolated areas and lack transportation. Therefore, they are unable to see a physician, visit the Indian Health Service, or go to a health care provider of any kind, let alone have someone visit them in their home. Is it a large problem, or are we talking about the exceptional person who falls through the cracks?

Doctor, do you have a sense of that?

Dr. **Kozoll**. I think the answer to your question is, yes, there are a large number of elderly Indians who are remote from services. I can speak specifically of the Cuba-Checkerboard area where there are some like 7,000 Navajos in a radius of perhaps 50 or 60 miles of Cuba. Of those, perhaps 500 to 800 are over the age of 65. I would estimate perhaps a third of those have regular and continuous contact with health services, a third are seen rarely if at all, and the other third are intermittent users, frequently for crisis situations. Again, I can't stress too much the outreach, education, and transportation components to any service program.

Ms. **Velasquez**. Senator Bingaman, I would like to make a comment in reference to Congressman Richardson's question to the first panel. His question was something about direct funding to the Indian Health Service or to the CHR Programs. My recommendation to that question I would like to say that direct contacts be made to the community health bases in order for some of the pueblos to develop their home health program, and certainly the budget cuts for the Community Health Representative Program, they're eliminating a lot of transportation that is being provided to the hospitals or the clinics. As a result this will cut back a lot of the health services.

So in my recommendations to you I would like to see a direct contract to the community health bases that are already existing to improve the health delivery system.

Senator **Bingaman**. Mary, did you want to make a comment on this?

Ms. **Brueggeman**. I would like to respond to your question about the number of people in need of home health care. I believe that there is a large number of Indian elderly that are not receiving the health care services that they need. As far as Dr. Kozoll said, oftentimes it is a crisis-oriented type of visit to a facility, and there is many times not the thought on the part of the provider of what is going to happen to that patient once they go home. This is where, in working with home health care, I see the gap in the service to the number of people whose health care needs are not met. I believe that there needs to be more emphasis in home health care, and the thought of continuity of care once the patient leaves the facility.

I also believe that through revision of regulations and extra dollars to the tribes and/or existing home health agencies for this delivery of service, the needs can be met. I don't think it is an obstacle that we cannot overcome.

Senator BINGAMAN. Thank you, again, for being here. I appreciate it very much. Why don't we dismiss this panel, and we have one more group—one more panel that we would like to bring forward.

This next panel will focus on long-term care. T.D. Smith, who is executive director of the Laguna Rainbow Corp., I believe is here. He is accompanied by Ray Goetting also of the Laguna Rainbow Corp. We would appreciate it if both gentlemen would come forward to testify.

Is Alta Bluehouse here from Ganado, AZ? I have not seen Alta, but if she is here, please come forward.

Dr. Richard Kalish is here, who is a social psychologist here in Santa Fe. We appreciate your being here very much as well.

Again, I would ask the witnesses if they could summarize their testimony if at all possible, and then after everyone has testified I will pose my questions then.

Mr. Smith, if you would like to go right ahead. We will hear your testimony first.

STATEMENT OF T.D. SMITH, NEW LAGUNA, NM, EXECUTIVE DIRECTOR, LAGUNA RAINBOW CORP., ACCOMPANIED BY RAY C. GOETTING, VICE PRESIDENT

Mr. SMITH. Thank you, Senator. As I set forth in my written presentation I would—my name is T.D. Smith. I am the executive director of the Laguna Rainbow Corp. I have with me today Mr. Ray Goetting. And inasmuch, Senator, as I have only been in my position for about 45 days, I felt it only right that someone more familiar with the operation may be here to help us. Also in our audience we have members of our elderly association. Our president was unable to come. However, our vice president, who is also Mr. Goetting, and we have Connie Smith, who is the treasurer, and also two of the members of that committee, Mr. and Mrs. E. Pradt, who came on their own.

I asked Mr. Goetting if he would make the presentation inasmuch as Mr. Goetting has served on the Advisory Board of the Congressional Office of Technical Assessment during the year of the IHS; has held many capacities on the Laguna Reservation. He is an American Indian with his home on the reservation and, therefore, has been a consultant and acting director until my appointment, and I'd like to start and present Mr. Ray Goetting.

Senator BINGAMAN. Thank you very much for being here, Mr. Goetting. We look forward to your testimony.

Mr. GOETTING. Also I'm one of the persons you're talking about in this program. Having reached the age of 60 sometime ago. I would like to say thank you for all of us and express a concern of the Laguna Council, because they have recently discussed the operation and asked us to do certain things. They all bear on the activity and categories that we have been given as to history, funding, facilities, and problems. I will try to touch on them in that order.

In the historical part of this the council discussed for a long time the need for the care that was not covered by IHS in regard to long-term care of the elderly, particularly because it has concentrated on outpatient and inpatient and preventive medicine.

Second, that the growth and the improvements in the health that has come by those efforts, has lengthened the age and the number of population over 60. We have 650, which is approximately 12 percent of the population of the tribal membership. We had some advisory consulting services the other day who told us that there might be a University of New Mexico study that indicates that the elderly over 60 in the past 10 years is doubling or has doubled. And incidentally on the way to the rostrum I noticed that one of our members, Mr. Ken Hunt, who is in the operation for the University of New Mexico, involved in this movie that is coming along, and I would like to introduce him as well.

I think though that in terms of cataloging, and this is what the council has asked us to do. Take those people who are over 60 and try to determine whether or not they're doing exactly as you have just questioned. Who and what are they receiving in terms of elderly care. So we're cataloging them in three stages or four stages really. First, those who need no assistance.

Second, those who have a requirement for home health services of some kind. And I would certainly like to compliment the previous panel's individual, Mary, from Rehoboth in her statement in regard to that. I will save a lot of time in regard to saying I would support her interpretation of the problems that we experience in delivering home health care.

The third stage is that group of people who do not require hospitalization but who need constant medication. Who are somewhat feeble but yet cannot take care of their homes and who need help. HUD has provided a congregate housing program for people who might be in that category with certain supportive services, nutrition, and so on. We have a facility that is included the CHSP program, and so I will touch on that in the facilities.

The fourth group are those who are unable to take care of themselves entirely and need a nursing home facility for adequate care. And we have that.

Those are the four classes of people that we're trying to catalog and follow them and track them through the operation in order to determine the need that we may have, and how much and when it can be served. One of the problems of doing this, of course, is transportation and handling of all the people to provide them whatever element of need they have, whether it be in the first, second, or third stages. We're handicapped in that activity due to inadequate transportation.

In funding that we have—a complete rundown of funding availability perhaps is not well known by all of the tribes. There is a record of operational activity from which we can draw on. And so in Laguna they established in the beginning a tribal corporation, Laguna Rainbow Corp., to consolidate all of the elderly efforts into one activity in order to reach all and avoid anyone from dropping through the cracks.

The funding we have has been from tribal funds to support the programs when participation is required. We participate in State capital outlay. We participated at one time in title III, which is sometimes restricted when the grantee has also title VI. We have title IV, which is intermittently in terms of the classification of activities that it supports. Title V we have secured through the All Indian Pueblo Council with four positions of employees. We have received senior companions, who sometimes visit and are confused with CHR's, and who they serve and who they visit. They're restricted to two clients, but everybody wants them.

As an instance we had one senior companion who had an automobile and could visit, and therefore did a lot more work and visited a lot more people than those without a car could handle. The difficulty is that it fooled people into thinking that senior companion, although restricted to two clients, could visit all the people in the village. And at Laguna we have six villages and the transportation is a significant problem; and we can't always cover it.

Going on, besides title VI, we have the home health care which was started, but is not now in effect. The HUD congregate housing, and the nutritional program it has, is titled CHSP. Then we have ICF [intermediate care facilities] funding from private pay for those who are above the poverty level; the Social Security that we receive in partial payment for those who need additional help; railroad retirement, the private annuities; and Medicaid for those who are eligible for the balance of uncovered expenses that are experienced.

So we handle in that activity a trust fund, because in some of those the individual is eligible to keep a portion of their money. And therefore, for their own personal use. So besides that, we need to operate a personal trust fund operation for those people that are in the nursing home. Then the Agricultural Department involved in commodities, and in some instances funds in lieu of commodities for the services and support that they provide.

I'm a little disappointed that the representative from Arizona may not be here, because in Arizona they don't have Medicaid, and because in different States there are different rules about how funds are handled. It proves that the inconsistent treatment from agency to agency, from department to department that we really need a consolidated integrated effort from all the resources that are available, and also that a policy is necessary to inform those agencies and those people involved. And every time a new change of administration comes along, it's a reeducational process that Indians are here, and they're a little bit different, and they need the help. And everytime they feel like that the Bureau of Indian Affairs is paying the expenses and no other requirement is necessary.

I did serve on the American Indian Policy Review Commission several years ago, who made a study in regard to the amount of per capita budgets of the United States which went to Indians as compared to non-Indians, and the non-Indians received more per capita funds assistance in the domestic programs than the native American Indians do even though they have treaty obligations to support their claim for services.

The facilities that we have at Laguna are the HUD facility consisting of 5 clusters of 8 units each or 40 apartments and a separate core building. Each apartment consists of one bedroom, bath and living room and kitchen and dining area combination. the core building consists of a laundry unit, kitchen, food storage unit, dining room, living room, rest rooms, a chapel, and administrative offices.

The tribal-owned nursing home facilities is constructed as an addition to the core facility of HUD and consists of single and double rooms for a 25-bed home with nursing and care rooms as required for this size home. The core facilities are used in conjunction with the nursing home so as to avoid duplication of space and equipment. The tribal funding was required under certain conditions. In order to avoid some confusion the tribe furnished the money to build the nursing home itself. So we have a combination of facilities for a common source of elderly activities.

You mentioned a moment ago to someone about the documentation and the amount of statistics required. In some areas we have been criticized where these individual programs or funds were supposedly to be maintained separately and where the contracts and agreements require separate accounting and statistical records. We attempted to save money by consolidating the activities; using common services and common facilities which we have to prorate and adjust to avoid the accusation of funding consolidation, comingling, and misappropriation. In that sort of thing, we lay ourselves open if the detailed records are not maintained adequately. We are suspect in some instances in that regard now.

The council requested that a review of the needs be made to determine if enlargement is necessary, and at what point will such an operation become self-supporting. We're in the process of doing that. We'll probably write a report which we might make available to you. The HUD formula for rental fees for the apartments is based on low-income applicants, without a ceiling on the value of the apartment being rented. If other than low-income retirees apply, an exorbitant rental is fixed. It is possible for a couple to buy and make payments on a trailer home for $150 a month, where as the apartment could be from $250 to $350 a month in excess of the value on the open market. Similar apartments are available in Albuquerque for less and furnished with swimming pools, saunas, exercise rooms and a living room center for operational visitations and gatherings.

Where low income or most elderly are on Social Security with unemployed children and their families, the elderly is the breadwinner and can't move to the HUD apartment or to the ICF even though they need care of that level. In some cases this condition amounts to elderly abuse, because the young family is dependent upon the Social Security check of the elder in order to survive. When abuse occurs by alcoholism, other ailments and peculiarities of the younger portion of the family, we have a problem taking care of the elderly. The council has asked us to prepare a report on the conditions of this in order to determine the legal rights and privileges by which we might even enter that home privately to determine how we can resolve the problem of difficulties that they're experiencing.

Due to some of the personal economic conditions CHSP housing are half full because of the these rates and this attitude. Their collections then are insufficient to care for the grounds, and vacant buildings allow excessive deterioration. Rate ceilings and welfare coordination to provide full care and full occupancy is needed, even if some changes are necessary in the law or the regulations. Of course, those over the poverty level have no FHA or any other program even to begin to finance themselves in suitable facilities until they reach the nursing home stage. Then, of course, they have to pay for their own if their income and their assets are sufficient.

The report on health conditions of our Laguna elderly in the various stages mentioned above will be available shortly. To the extent the programs are available for assistance will be evaluated, and it is estimated that—what we know already to require added funds to the Older Americans Act to hold our own in providing minimum services we now enjoy. With the increase of elderly in the age brackets and the decrease in funding, the level of care available seems to be decreasing really in a dramatic significant manner.

Thank you again.

[The prepared statement of Mr. T.D. Smith follows:]

LAGUNA RAINBOW CORPORATION
LAGUNA RAINBOW NURSING CENTER
& ELDERLY CARE CENTER

TESTIMONY

TO THE

SENATE SPECIAL COMMITTEE ON AGING

THE HONORABLE JEFF BINGAMAN
UNITED STATES SENATOR - CHAIRMAN

ON
"THE CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS"

Presented in Santa Fe, New Mexico
September 3, 1986

By and For: Laguna Rainbow Corporation
Laguna Rainbow Nursing Center
and Elderly Care Center

LAGUNA RAINBOW CORPORATION

LONG TERM ELDERLY CARE - PUEBLO OF LAGUNA

The Pueblo of Laguna, like all other Indian Tribes, experienced most of its health care activities through the Indian Health Service, years ago under the Department of the Interior, but currently under the Department of Health and Human Services. When the Department of Housing and Urban Development provided Indian Housing, an element of consideration was given to conveniences for the elderly and the handicapped, but not from a health care concern. When these programs became common, and provided relief to those in sub-standard houses, those who qualified moved out of the older homes. In many cases this left the elderly alone in the old substandard house. The tradition and culture of nuclear and extended families who cared for the elderly was interrupted with considerable difficulties, and has since developed problems. Congregate housing and congregate feeding programs of HUD provided some relief. Title VI and other nutrition programs of the Older Americans Act have been very beneficial to the elderly. As these programs became better understood, the Tribes have recognized that the problems of health and care of the elderly are steadily, and in some cases, dramatically increasing. When the Pueblo of Laguna realized that long term care needs were growing, it discovered that nursing home needs were being met away from home. The families and relatives found it expensive and difficult to visit their parents and grandparents in off-reservation locations. The Pueblo of Laguna Council discussed the needs for several years, and when a Congregate Housing project of HUD became a reality, long term care became a topic of discussion along with Nursing Home Needs.

In the planning of the congregate housing project, an ICF level Nursing Home facility was considered. To avoid certain funding and coordination problems, the Pueblo of Laguna decided to finance the ICF nursing home portion of construction from its own tribal funds. The tribe established the capacity for meeting its own forseeable needs, and recognized that it would be necessary to provide continual financial support for operations. The growing need of the Laguna elderly, would eventually require expanding the capacity, hopefully to a point of becoming self supporting. The Council is now requesting that the current and future needs be investigated.

During construction the Pueblo of Laguna Council chartered an internal organization entitled "Laguna Rainbow Corporation." This charter assigned all elderly activities to the corporation, including the programs under the Older Americans Act, a portion of the congregate housing special program (CHSP), Senior Olympics and other elderly activities.

The Elderly people of the Pueblo of Laguna have organized themselves and just recently established a single advisory committee under the Laguna Rainbow Corporation to handle Title VI as well as other activities which are all interrelated. This assures continuity of membership and representation in the New Mexico Indian Council on Aging, the National Council on Aging, and membership in local, state, and federal sponsored activities. This will provide for a vehicle to permit the elderly to be heard, and contribute to the development of programs and budgets for satisfying those needs.

Funding resources have come from several agencies of Tribal, State, and Federal governments. Following is a list of programs processed through the Laguna Rainbow Corporation.

Tribal funds to support the ICF.

Tribal funds to support participating requirements of State and Federal programs.

Title III (discontinued)

Title IV (Intermittent)

Title VI Nutrition - Current

Medicaid for eligible ICF residents.

New Mexico State Capital Outlay programs.

Home Health Care (discontinued)

Private fees for ICF residents.

Social Security, SSI, RR Retirement, and other annuities for ICF residents as appropriate.

Senior Companion/ACTION programs with small amounts.

A Patient Trust fund account is maintained to care for the needs of patients which is otherwise not allowable under other funding. This fund is an allowance to be retained for the patient from their Social Security, RR Retirement, etc. in the amount of $30.00 per month. The balance of their checks are applied to the fees for care, with Medicaid picking up the remainder of the allowable monthly rate for those eligibles.

The Elderly organizations conduct fund raising activities to provide support for needs as they determine, and are able to do so.

Individuals have contributed both funds and articles (piano) as memorials to the patients, in appreciation for the services provided by the home and its employees. Churches and other individuals provide personal items on various occasions such as Christmas and birthdays.

These expressions of appreciation help the morale and services of the employees.

The structural facility is a combination of the HUD Congregate housing and the Tribal Nursing Home.

The Congregate housing consists of five (5) clusters of eight apartments each for a total of 40 units, together with a Core building containing a laundry unit, a kitchen, dining room, restrooms, living and activity room, chapel, and administrative offices. The apartments are one bedroom, living room, bath and a combination dining area and kitchenette.

The Nuring Home adjoins the Core building of the HUD project, and shares the laundry, kitchen, dining room, chapel, living and activity room, and the Laguna Rainbow Corporation occupies the offices. In addition the Nursing Home as an ICF unit is licensed under the New Mexico State Licensing laws, and contains the rooms and equipment necessary for a twenty-five bed nursing home.

The arrangement of the buildings provided for a courtyard or plaza in the center for such outside activities as can be arranged. All of the Elderly of the reservation are invited to attend activities, and the Elderly Organization meets there on a monthly basis. A special organization is composed of the relatives of the ICF patients, who, also, raise funds and assist in anyway possible.

There are 650 people over 60 years of age, many of whom need health care services of some kind, and some should be in the Congregate housing where counseling and nursing assistance is only a step away, and where a nutritional program exists for them. One of the problem stems partly from the fact that with unemployment so high, the elderly has the income for the group for Social Security, SSI, RR Retirement, etc. The family sees it as an economical drain when the elderly are moved into either the CHSP apartments or even the ICF Nursing Home, since both have fee charges. In some instances, an elderly couple on retirement can buy and live in a mobile home cheaper then in the CHSP. Consequently, they are not closely watched, even though they may participate in one of the Nutrition feeding programs. If and when transportation is not possible or available, home delivery of a noon meal five days per week is possible. If the Federal programs are reduced so will these activities be reduced. When persons are unable to provide personal transportation, the need of program transportation is necessary. Transportation is entirely inadequate now.

In some instances we believe some of these problems can actually be classed as elderly abuse. The question of the authority to enter private homes to make or enforce corrections is being considered by the Laguna Rainbow Corporation, and a report will soon be submitted to the Council.

The Council is now reviewing the Charter of the Laguna Rainbow Corporation to determine if adequate and proper authority exists to provide the kind of service the Council may determine essential.

The coordination required for all the agencies involved needs strengthening. Policies and procedures for operating all programs concerning the elderly need to be administered by a single organization at the local level. A tracking mechanism for the elderly as their health needs envolve from self sufficiency to Nursing Home needs. Equitable rates for facilities and services provided must be competitive in order for the elderly Indian people to receive care equal to that available in municipalities such as Albuquerque.

For home health care to be provided and proper medical evaluations to be made, it would appear appropriate for the Indian Health Service to provide and utilize field workers such as the CHR Program workers. Medicare arrangements as now made at Clinics and Hospitals would be an advantage. Even Medicaid if available would be a big help in funding minimal health care requirements in the elderly's own home.

Since much of the considerations are economical, a welfare system should be included as part of the overall planning and coordination. If one local organization were to handle all elderly programs on the reservation one office should be able to coordinate the needs with the appropriate program. The elderly would then need to contact one office for all the information necessary to get help. The concerns, also, include Indian Veterans who are eligible for VA services, and VA needs to know what is available on the reservation.

The Tribal Governments and those of us who understand that there are unmet needs, and the current level of funding is inadequate, recognize the growth of numbers in the elderly population will result in less services. The statistics of growth now reflects that the elderly population in New Mexico has doubled in the past ten (10) years. The need for the continuation of the Older Americans Act, and an increase in funds provided thereunder is essential to maintain even the current level of services. Your efforts in our behalf is greatly appreciated.

The above are our remarks concerning the history of elderly care at the Pueblo of Laguna, the funding available, the facilities, a brief of the problems, and some suggestions, but we would be happy to answer any questions should more details be desired.

Thank you very much for this opportunity.

Respectfully,

TD. Smith
T.D. Smith
Executive Director

Ray C. Goetting
Acting Assistant - Executive Director

Senator **Bingaman**. Thank you very much. We appreciate your testimony.

Yes, Dr. Kalish, if you would go ahead and give us your testimony.

STATEMENT OF RICHARD A. KALISH, PH.D., SANTA FE, NM, SOCIAL PSYCHOLOGIST AND SOCIAL GERONTOLOGIST

Dr. **Kalish**. Being the last speaker before lunch always has its hazards, and I'll take into consideration the condition of your stomaches as well as other interests.

My name is Richard Kalish. I'm a social psychologist and social gerontologist living in Santa Fe. I began to work in the field of aging 20 years ago, actually a little longer. During that time most of my worklife has involved teaching, writing, research and program development. Some of that effort has involved minority aging, only a little bit of which has been native American aging; most of it has been with other minorities.

However, today I'm really representing someone else, Ted Koff, who is the director of the Long Term Care Gerontology Center at the University of Arizona. Ted was originally scheduled to be here, but because of work plans was unable to attend. So he asked me to fill in for him. I will read his comments, but I have already read them to myself and I want to say Ted and I usually agree. I can support everything that he and I are about to say.

This testimony, presented by the Arizona Long Term Care Gerontology Center, has been gathered as a result of the center's activities since 1984 relative to issues affecting the welfare of older Indians.

ALTGC has provided technical assistance in the planning and management of services to the elderly for several native American tribes and has coordinated two national conferences on the problems of older Indians in need of long-term care services. While this testimony has been developed as a result of interaction with Indians and service providers, it represents only the thinking of ALTGC.

It should be stated at the outset that most, if not all, of the problems of delivery of chronic care services to Indians are the same as those confronted by society as a whole. Older Indians, like other elderly, need a continuum of health care, but concerns about financing, access to services, coordination of services, staffing, and evaluation of services that are common to all the aged are exacerbated by the unique economic and environmental problems of older Indians. This is especially true of Indians living on reservations and in other rural isolated areas.

Solutions to these problems as proposed for the larger society are therefore inadequate to address the needs of older Indians, which require a more intense level of intervention. Because of their special circumstances, older Indians have special needs that should be addressed by a single coordinated approach targeted to this population. It is our belief that modification of existing plans that have evolved in mostly urban settings cannot be successfully applied to respond to the Indian population. Such modification should not be attempted. Rather, a new set of expectation and program realistically designed to meet the needs of older Indians is required.

For example, while nursing homes with very few beds cannot be administered efficiently, most reservations need only a limited number of long-term care beds, so the only alternatives are a small nursing home or transfer of Indians off the reservation to non-Indian institutions.

Nutrition and recreation programs funded with Federal dollars may not be sensitive to the cultural patterns of Indians and may require performance criteria that are inappropriate to the needs of older native Americans. We heard earlier this morning some of the issues of HFCA. This is a repeat of them in another context.

Senator Bingaman, to respond to a question you proposed earlier—almost no research had been done to define the characteristics of a continuum of care that would specifically address the needs of older Indians that are related to health conditions, housing, cultural beliefs, family support systems and transportation.

There is considerable confusion about the roles of the various funding agencies that have responsibility for providing services to Indians.

The following recommendations have been compiled from those emerging from conferences conducted by the Arizona Long Term Care Gerontology Center in Tucson in 1984—and I was a presenter, actually master of ceremonies at that session. Larry Curley is here, and he will recall that quite well—and at Albuquerque in 1985 as well as from information obtained in the course of providing technical assistance to Indian tribes.

Here are the recommendations.

First. Agencies that provide services to older native Americans should develop a standard definition of levels of care including: personal, intermediate and skilled care.

Second. Tribes should be given authority to bill HFCA and other third party payers directly in order to ensure reimbursement for services generated by the tribe. That issue has come up already.

Third. "Swing" beds and respite care should be made a part of Indian Health Service's hospital and clinic services.

Fourth. Working relationships with certified and licensed home health care agencies should be established by tribes, with special attention to acquiring technical assistance that will lead to establishment of licensed home health care agencies on the reservations.

Fifth. The various levels of Government that deliver health care to elderly Indians should enter into a formal agreement delineating and clarifying the responsibilities of each and removing restrictions on tribal involvement in planning and providing health care programs.

Sixth. Eligibility criteria requirements established by State, county and local health care programs that serve the elderly should be reviewed and modified to remove restrictions.

Seventh. Assessment and case management services should be incorporated into the Indian Health Service delivery system.

Eighth. Home renovation and repair programs should be instituted, using volunteers to improve the housing occupied by elderly Indians, thereby permitting them to retain their homes and independence as long as possible.

Ninth. Federal funds should be made available to construct and operate suitable housing for the elderly on the reservations. The urban models for apartments and congregate housing are not appropriate, so alternative supportive environments for elderly Indians should be designed and created.

Tenth. Agreements should be negotiated with Federal agencies in order to eliminate program requirements that inhibit intergenerational nutrition services.

Eleventh. Health educators and nutritional consultants who work with elderly Indians should be trained to understand the special nutritional requirements and cultural distinctions of native American populations.

Twelfth. National legislation aimed at the development of education and service programs for reducing the incidence of abuse, neglect, and exploitation among the Nation's Indian elderly should be developed and implemented.

And finally a statement on research. National Agency Council should be established and should develop a research agenda based on the specific needs of elderly Indians. Here again, Senator Bingaman, I recall your question about what is the extent of the needs. And it may seem that we really may not know. Among the priorities of this research council should be: First, encouraging the gathering of meaningful data on the characteristics of the elderly Indian population; second, service cost and evaluation statistics; third, identification of funding sources; and fourth, participation by researchers who are sensitive to the unique cultural aspects of Indian communities.

Just to add a final comment of my own to this: It would seem as though one of the major concerns of this research is what is the extent, and what are the kinds of health conditions and service-providing conditions, that differentiate the native American communities, particularly in the Southwest, from the other community; and what kinds of services can most effectively be provided to these people. Thank you.

Senator BINGAMAN. Thank you very much, Dr. Kalish. I do not have any questions so why don't we go ahead and adjourn for lunch. I gather we have some lunch plans. I understand that most of the elderly who were bused here today will have lunch with us, and we have a room set aside for all of those folks. My staff is outside ready to direct people to that room.

Second, I want to thank Eileen Lujan of the Eight Northern Pueblos and her staff for preparing food for our witnesses. Consuelo Trujillo on my staff will direct people to that room.

Finally, the Santa Fe Indian School prepared extra sack lunches which are available for anyone who does not have a lunch. So if you fall into any of those categories, there is some kind of lunch provided for you.

We will start again at 1:45 and we should be able to conclude shortly after 3. So thank you again for coming. I appreciate the testimony.

[From 12:30 to 1:15 p.m. a recess was taken.]

Senator BINGAMAN. Our next panel is quite large. This panel will give us the State and Federal perspective. As I mention your name, please come forward and we will begin.

George Buzzard, Acting Associate Director, Office of Planning, Evaluation and Legislation, Indian Health Service. George, if you could come forward, please.

Robert Carr, Director of Social Services for the Albuquerque Area Office of the BIA.

Daniel F. Bonner, Associate Director, Domestic and Anti-Poverty Programs for ACTION.

Rafael Mecham, the Director of Office of Indian Programs, U.S. Department of Housing and Urban Development, is here.

Gene Dickey, Regional Administrator for the Food and Nutrition Services in the Department of Agriculture.

Let's take those individuals first. Then following this panel we will hear from the State representatives.

I gather we would like to have Dr. Tempest accompany Mr. Buzzard, if we could.

Let me try to give you folks the same advice I've been trying to give others. It hasn't worked very well. If you could try to summarize your testimony instead of going through it verbatim that would help. Try to keep it to about 5 minutes if at all possible, so we will have some time for questions. You might try to follow the policy that we began to pursue earlier, and that is to hold the microphone up toward your mouth while you're talking so everybody can hear you.

Mr. Buzzard if you will please go ahead. We appreciate you being here.

STATEMENT OF GEORGE BUZZARD, ROCKVILLE, MD, ACTING ASSOCIATE DIRECTOR, OFFICE OF PLANNING, EVALUATION AND LEGISLATION, INDIAN HEALTH SERVICE, ACCOMPANIED BY BRUCE TEMPEST, M.D., GALLUP, NM

Mr. BUZZARD. Thank you, Senator. I am George Buzzard, Deputy Associate Director, Office of Service. I am accompanied this morning by Dr. Bruce Tempest of our medical center in Gallup, NM. He is here to answer any questions regarding the IHS clinical program.

I'm very pleased to be here today to provide information on the programs of the Indian Health Service, and other programs, particularly with regard to the Indian elderly.

The IHS provides a comprehensive program encompassing preventive, acute, and chronic care services to American Indians and Alaska Natives of all ages.

The success of our approach to health care is attested to by the increasing life expectancy of our service population. A recent IHS report, revealed that in the 10-year period from 1970 to 1980 the average life expectancy of both sexes increased by 6 years. The number of our service population may now expect to live to an age of greater than 70 years. While this is still below the 73.7 years of the U.S. population, it does reveal that the Indian communities are developing an aging population.

Currently, the population age 63 and above constitutes about 5.3 percent of our service population, or approximately 52,000 individuals. And of this group approximately 33,000 of these individuals are eligible for Medicare. Under the provisions of the Public Law

94-437, the Indian Health Care Improvement Act, the IHS is allowed to bill Medicare for the services provided to eligible Indian patients. The funds recovered under these provisions are by law to be used to redress deficiencies identified by the Joint Commission on Accreditation of Hospitals. In fiscal year 1985 the IHS collected under Medicare fees in excess of $17 million.

The provision of health services for the elderly requires many resources, and in fiscal year 1985, 10 percent of all visits to the Indian Health Service ambulatory facility and 18 percent of all inpatient hospital days were by patients 65 and above. An analysis of the utilization of these resources revealed that the services provided to those older than 65 were more resources than for our younger patients.

We have developed a number of approaches that address the health care for the elderly. In the area of preventive programs IHS does operate programs in social work, nutrition, health education and environmental issues and disease-related areas to increase health maintenance behaviors in the elderly population. An example of this preventive care program is the central diabetes program. It utilizes a multidisciplinary team. The program has targeted the prevention of such catastrophic sequelae of type II diabetes as amputations and end-stage renal disease. These problems that incapacitate many older patients have been reduced through the collective efforts of IHS providers, tribal-community groups, and the National Diabetes Advisory Board.

IHS funded tribal health activities also include many efforts in this area. Tribally operated Community Health Care Representative Programs have had as a main emphasis, health promotion and disease prevention among the elderly populations and many of these contracts do have gerontology components.

While our acute care programs encompass a full range of ambulatory inpatient care, or efforts in providing chronic care to the elderly is improving. This care is typified by programs involving the collaborative efforts of IHS providers and tribally operated home health care agencies which develop discharge and home care plans for the elderly.

Although IHS has not established an Office of Gerontology Services, in 1978 the IHS designated the social workers coordinators for aging activities. Recently one of our areas with a large elderly population and minimal State or local resources has established a geriatrics health coordinator position and hired a qualified physician to address the needs of the elderly. Other areas are currently evaluating the need for such specialized skills. IHS does help in providing specialized training for health prevention in the areas of nutritional needs, immunizational requirements and the prevention of toxic drug interactions.

Indian Health Care does recognize there is a growing elderly population in American Indian communities. Problems are now surfacing in these communities regarding long-term care of chronic disease. Institutionalization of elderly individuals is clearly a last resort approach to chronic care. And this is certainly not consistent with the community-based wellness approach that is the core of IHS professional goals. Rather than warehousing individuals the IHS would much rather work with Indian communities to develop innovative home and community-based approaches to the chronic care needs of the elderly.

While these examples serve to demonstrate how the IHS has developed programs appropriate to the needs of the aging Indian population, further refinement of the approaches to these issues is ongoing.

I hope this illustrative, rather than exhaustive, presentation of information aids the committee in its understanding of the IHS approach to health care for elderly American Indians and Alaskan Natives.

Senator, that concludes my presentation. I will be most happy to answer any questions you may have at this time or at the end of the panel.

[The prepared statement of Mr. Buzzard follows:]

STATEMENT

BY

GEORGE BUZZARD

DEPUTY ASSOCIATE DIRECTOR
OFFICE OF PLANNING EVALUATION AND LEGISLATION
INDIAN HEALTH SERVICE
PUBLIC HEATH SERVICE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

AT

SANTA FE, NEW MEXICO

SEPTEMBER 3, 1986

Mr. Chairman and Members of the Committee: I am George Buzzard, Deputy Associate Director, Office of Planning, Evaluation and Legislation, Indian Health Service. I am accompanied this morning by Dr. Bruce Tempest of our medical center in Albuquerque.

I am pleased to be here today to provide information on the programs of the Indian Health Service (IHS) and other Department programs, particularly with regard to the Indian elderly.

The Indian Health Service provides a comprehensive program encompassing preventive, acute, and chronic care services to American Indians and Alaska Natives of all ages. The hallmark of the IHS program has been a balanced set of services designed to meet the epidemiologically defined needs of our Service population. The research activities regarding elder care needs are limited to this epidemiologic analysis.

The success of this approach is attested to by the increasing life expectancy at birth of American Indians and Alaska Natives. A recent report prepared by the IHS staff analyzed the life expectancy at birth of our Service population for the period 1979-81 and compared these statistics to similar data from the period 1969-71. This study revealed that in the 10 year period described, the average life expectancy at birth for American Indians and Alaska Natives of both sexes increased an average of 6.0 years. The members of our Service population may expect to live to an age of greater than 70 years. While this is still below the figures for the U.S. population as a whole, who may expect to live to 73.7 years (1980), it does reveal that an aging population is developing in Indian country.

Currently the population aged 65 and above constitutes about 5.3% of the IHS service population. In absolute numbers, this means that approximately 52,000 individuals of the 989,000 IHS service population are aged 65 and above. Of this elderly group, approximately 33,000 are eligible for Medicare. Under provisions of P.L. 94-437, the IHS is allowed to bill Medicare for services provided to eligible Indian patients. The funds recovered under these provisions are by law to be used to redress deficiencies identified by the Joint Commission on Accreditation of Hospitals. In FY 85 the IHS collected $17,313,971 under Medicare.

The provision of health services to this population requires many resources. In FY 1985, the number of visits to IHS ambulatory facilities by patients aged 65 and above accounted for approximately 10% of all visits. The number of inpatient hospital days accounted for by this group totaled almost 18% of hospital days for patient care in IHS hospitals. An analysis of resource intensiveness reveals that services provided to those 65 years and older were more resource intensive than for younger patients. If national trends in this population may be extrapolated to our service population, the use of IHS acute services by the elderly will increase, resulting in an ever greater proportional use of IHS resources.

The Indian Health Service recognizes these trends and has developed a number of programmatic approaches to address the issues of health care for the elderly.

In the area of preventive programs, IHS has, either through its directly operated facilities or in conjunction with tribal health programs, initiated many activities. In its directly operated programs specific curricula have been developed in nutrition, health education, environmental issues, and disease-related areas (such as diabetes) to increase health maintenance behaviors in elderly populations. This is typified by the Central Diabetes Program in the IHS. This program, which utilizes a multi-disciplinary team, has been operational for seven years. The program emphasis has targeted the prevention of such catastrophic sequelae of Type II diabetes as amputations and end-stage renal disease. Through the collaborative efforts of IHS providers, tribal-community groups, and the National Diabetes Advisory Board, a program was developed to prevent the above problems which incapacitate many, primarily older, Indian patients.

IHS funded tribal health activities also include many efforts in this area. Tribally operated Community Health Representative programs have had as a main emphasis, health promotion among elderly populations. This is a well defined element of the scope of work negotiated with the Tribes for Community Health Representatives.

Acute care for the elderly is a vital, ongoing element of the IHS program. As the statistics presented earlier suggest, the elderly receive a disproportionately higher share of care than other age groups. The acute care programs encompass a full range of ambulatory and inpatient care.

Chronic care programs utilize ambulatory, inpatient, and community services. These programs involve a variety of providers including physicians, nursing personnel, both in facilities and communities, nutritionists, dentists, physical therapists and many others. These programs reflect the efforts of

IHS and tribal employees. Our efforts in providing chronic care to the elderly and others is typified by programs involving the collaborative efforts of IHS providers and tribally operated home health care agencies. In these programs, IHS providers work together with tribal employees to effectively develop discharge and home care plans for elderly individuals discharged from inpatient care, but requiring continued care in the home. The continued monitoring of the patient's health status by this team is paramount to early diagnosis and intervention or prevention. This approach has proved successful in many locations over time. The Zuni Tribal Home Health Care Agency has, for example, been quite successful over the last five years in working closely with the staff of the IHS Zuni Comprehensive Health Center.

With regard to the question raised in your letter of invitation, the IHS has not established at the national level, an office of Gerontology Services. However, one Area with a large elderly populatic , and minimal State or local resources available to this population, has established a Geriatric Health Coordinator position and hired a qualified physician to address needs in the Area. Other Areas currently are evaluating the need for such specialized skills. Specialized geriatric training for health professionals currently working in Indian communities covering such topics as prevention of toxic drug interactions, nutritional needs of the elderly, and immunization requirements of aging populations is rountinely provided.

IHS recognizes that there is a growing elderly population in American Indians/Alaska Natives communities. Problems are now surfacing in these communities regarding long term care of chronic disease. As indicated previously in this testimony, the IHS is committed to home health care as a mainstay of care. Institutionalization of elderly individuals is clearly a last resort approach to chronic care that is not consistent with the community - based wellness approach that is the core of IHS professional goals. Rather than inappropriately institutionalizing individuals the IHS would much rather work with Indian communities to develop innovative home and community based approaches to the chronic care needs of the elderly.

These examples serve to demonstrate how the IHS has developed programs appropriate to the needs of an aging Indian population. Further refinement of the approaches to these issues is ongoing. The IHS is part of the Indian Elders Initiative Task Group sponsored by the Office of the Assistant Secretary for Human Development Services. This Task Group, which has representation from the Administration on Aging, the Administration for Native Americans, the Indian Health Service and other elements of the Department of Health and Human Services, is working steadily to enhance and coordinate policy development in Indian elderly health care issues.

I hope that this illustrative, rather than exhaustive, presentation of information aids the Committee in its understanding of the Indian Health Service approach to health care for elderly American Indians and Alaska Natives.

This concludes my discussion of IHS programs. Since representatives of the Administration of Aging and the Health Care Financing Administration cannot be present today, I will provide the following statements on behalf of these programs.

Administration Aging (AoA)

Title VI, "Grants to Indian Tribes for Supportive and Nutritional Services," is the program for older Indians on or near Indian reservations and is the most familiar Older Americans Act program for elderly Native Americans. Its funding has increased from the original $6 million for 84 tribes in 1980, but the number of tribal organizations applying for and receiving Title VI funds has also grown. Currently there are 124 Title VI grantees, and the Administration on Aging is in the process of reviewing applications from an additional number of tribal organizations. Fiscal Year 1986 funding for Title VI is $7,177,500. The President's budget request for the program in Fiscal Year 1987 is $7.5 million, which is the amount originally appropriated for Fiscal Year 1986 before adjusting for the Gramm-Rudman-Hollings sequestration.

- The most recent Title VI data cover Fiscal Year 1984 and reflect the following:

- Of the eligible population of 18,927, 94 percent (17,730 persons) received one or more supportive services.

- Of the 17,730 older Indians participating in nutrition services, 69 percent received their meals in a congregate setting and 31 percent received their meals at home.

- About 61 percent of the Title VI expenditures were for meals.

- The supportive services provided most frequently continue to be transportation, and information and referral.

Indian Tribes also have a number of opportunities under Title IV of the Older American Act (Training, Research, and Demonstration Projects). Every year AoA has awarded a Title IV contract to an Indian owned firm to provide training and technical assistance on a national basis. The contract for the first five years was with ACKCO, Inc., and the current contract is with Native American Consultants, Inc. (NACI).

In Fiscal Year 1985 the Administration on Aging made a special one-time award of $2 million of Title IV funds to strengthen tribal systems for serving older persons. One hundred four grants were awarded to foster education and training, planning and resource development, research and demonstrations, program coordination, and cooperative management. Indian Tribes will continue as always to be eligible to apply for regular Title IV funding and will be specifically mentioned as eligible to apply for certain categories of grants in the next Office of Human Development Services Coordinated Discretionary Program (CDP) announcement. AoA plans to provide increased technical assistance designed to strengthen the Tribes' capacities to apply for Title IV funds under the CDP.

AoA has also aided the National Indian Council on Aging (NICOA) with Title IV funds since 1979. NICOA has produced numerous written materials profiling demographics and the needs of elderly Indians, and has produced materials to help elderly Indians to access services. AoA funds have enabled NICOA to advocate for the needs of elders and to provide technical assistance to Indian organizations and Tribes across the country.

Title III of the Older American Act provides "Grants for State and Community Programs on Aging". Older members of Indian Tribes and Alaska Native Groups have always had the same rights to receive services under Title III as other older persons. To the extent that older Native Americans are living in conditions of great economic or social need, they should be included in the target population for receipt of services, unless the tribal organization representing them has elected to receive a Title VI award. (The Act prohibits an older Native American who is eligible to receive services under Title VI from receiving services under Title III.) During Fiscal Year 1985, 49,619 Indian elders received supportive services under Title III, Part B; 30,000 received congregate meals under Title III, Part C-1; and 7,770 received home-delivered meals under Title III, Part C-2.

Title III also provides that Indian reservations may apply to the State Agency on Aging for designation as planning and service areas. At this time several such planning and service areas have been established, and seven Area Agencies on Aging are sponsored by Indian Tribes.

You have asked us to report on the status of an "Indian desk" in AoA. The Administration on Aging has created an Office of State and Tribal Programs in order to give more attention to State and Indian issues and programs. Headed by a high level federal official reporting directly to the Commissioner on Aging, the Associate Commissioner for State and Tribal Programs, this office provides oversight for services to Indian Tribes under both Title III and VI. Both the Commissioner on Aging and the Associate Commissioner welcome input from the Tribes about the law, regulations, and program direction of Titles III and VI.

AoA has cooperated with other Federal agencies that provide services to Indian Tribes. The U.S. Department of Agriculture (USDA), Food and Nutrition Service, has participated in the meals portion of Title VI. The Department of Housing and Urban Development has aided some Tribes in building multipurpose senior centers in which the Title VI nutrition and supportive services take place. In addition, the information and referral portion of the Tribes' program may be paid for by the Indian Health Service.

Health Care Financing Administration

Through treaty and legislation, the Federal government has established its obligation to provide health care to American Indians and Alaska Natives, primarily through the Indian Health Service (IHS . In addition, American Indians receive Medicaid and Medicare benefits when they meet the eligibility criteria of those programs.

In 1976, as a result of Congress' concern that IHS funds needed to be supplemented to improve the quality of care in Service facilities, Title IV of the Indian Health Care Improvement Act was passed to provide that IHS facilities, unlike other Federal facilities, could receive Medicare and Medicaid payments. The conditions placed on these funds were that they were to improve services to Indians and not to substitute for IHS funds. The payments were to go into a special fund and be used by facilities to address deficiencies and thus be able to be certified by Medicare or Medicaid or accredited by the Joint Commission on Accreditation of Hospitals. The funds were originally to be available only until hospitals could achieve compliance with Medicare and Medicaid requirements, which all facilities for the first time met in 1981. However it became clear that in order to maintain compliance, Medicare and Medicaid funds would continue to be necessary. IHS facilities continue to be eligible to receive the funds.

Under the Indian Health Care Improvement Act, hospitals and skilled nursing facilities are eligible to be reimbursed by the Medicare program. Generally for these services the provider is allowed to bill Medicare beneficiaries for deductibles and co-insurance, however, Indian patients are not responsible for the cost of care received in IHS facilities. Therefore the cost of the Medicare co-insurance and deductibles is absorbed by the Federal government.

The Medicaid program will pay for all services provided by IHS. One hundred per cent of the Medicaid payment for services provided in an IHS facility is reimbursed from Federal funds. Services to Ind ns provided through a contract with IHS are reimbursed using the standard FMAP (Federal Medicaid Assistance Percentages).

Since the implementation of the Act, there has been growth both in the Indian population served and in program costs.

- Between 1978 and 1985, Medicare and Medicaid reimbursement to IHS has grown from $2.1 million ($1.8 million for Medicare and $.35 million for Medicaid) to $32.9 million ($15.6 million for Medicare and $17.3 million for Medicaid.) Medicare and Medicaid reimbursement for service to Indians is expected to be about $52 million in FY 1986.

- Among the IHS population of 963,294 in 1985 there were 17,592 Medicare beneficiaries served, and 68,763 Medicaid beneficiaries served for a total of 86,355 Indian beneficiaries served during fiscal 1985.

In 1983 when we implemented the prospective payment system (PPS) for Medicare, IHS hospitals were included under the system, and began receiving a prospectively determined rate for each discharge. These facilities are in a unique situation by having a single intermediary and carrier, New Mexico Blue Cross, responsible for the payment of all IHS Medicare claims. However, unlike other PPS hospitals whose rates are based, during a transition period, on a blend of their own individual experience and the national rates, reimbursement for IHS facilities is based on the average cost for all IHS hospitals, (except in the State of Alaska, where the rate is based on an average of all that State's hospitals) and a percentage of a Federal prospective rate. To adjust the Federal portion of the PPS payment to IHS hospitals, we have also developed a separate wage index for the hospitals in the contiguous United States and for hospitals in Alaska.

Many of the issues arising from IHS/Health Care Financing Administration (HCFA) relationship result from both agencies' efforts to accomodate their normal operating procedures to achieve the goal of improving the health status of Indians. For example, IHS facilities had no billing capability prior to the enactment of the Indian Health Care Improvement Act. With the automation of the billing operations within the facilities and area offices, the IHS has overcome major billing problems.

In addition, it has sometimes been difficult for IHS to identify Indians who are eligible for Medicaid coverage. Indian patients have no legal obligation to provide IHS with information on their third party coverage in order to receive care through IHS, and many do not do so. IHS and HCFA regional offices have worked with State Medicaid programs so that a number of States now provide the IHS area office or facility with updated lists of Medicaid enrollees.

Although there is no interagency agreement between the IHS and HCFA, our activities are coordinated through our regional offices and headquarters, and the goal is to improve the quality of care in IHS facilities.

Dr. Tempest and I will be happy to answer any questions about IHS programs

Senator **Bingaman**. I think I will wait until the end of the panel, then I will address a couple of questions to you all.

Mr. Carr, would you go ahead, please.

STATEMENT OF ROBERT CARR, ALBUQUERQUE, NM, DIRECTOR OF SOCIAL SERVICES, BUREAU OF INDIAN AFFAIRS

Mr. **Carr**. Senator Bingaman, I'm pleased to be here today to discuss with you the role of the Bureau of Indian Affairs in the health care of Indian elders.

To summarize my testimony—then I would like to provide a few of my observations at the end—there are basically three areas that the Bureau becomes involved in, as IHS is the primary Federal agency that provides health care services. First, the Bureau is able to provide only limited financial assistance to those elders who are not eligible for any other public assistance program. So it's limited. And because of the restrictiveness of the Bureau's eligibility criteria for this assistance, the number served is very limited and makes up only a small portion of the client caseload in the Albuquerque area.

The second area that we're involved in the area of health care is the direct social work services to Indian elders on the reservations. Basically they consist of home visits in their own homes and in the nursing homes, assisting with nursing home placements, helping their families to cope with emotions and changes in roles brought about by out of home placements; and arranging for and helping Indian elders apply for various types of public assistances.

The third area of involvement is providing technical assistance services to the tribes in developing long-term plans for comprehensive health and social services programs for the elders. Probably the most important role that the Bureau's Social Services Program plays is that of providing technical assistance in the development of direct services to the Indian elders.

Just a few observations on the provision of comprehensive health services. One needs to look at the number of disciplines involved in the provision of comprehensive health care services to Indian people. One must also look at the number of laws that regulate the health services. Since regulations are generally restricted to specific programs, it becomes extremely difficult to bring about comprehensive health services. Because of the restrictive nature of regulations, services are fragmented. Take, for example, the Bureau's Social Services Program. Its role is pretty much limited to providing temporary custodial care services for a limited period of time. To obtain long-term services, the Indian elder must deal with the State's Medical Assistance Program and other public assistance programs such as SSI. The number of agencies and programs that are involved in bringing about health care services are many, and that makes the provision of health care services extremely complex.

There is a critical need for trained personnel out in the field, both social workers and people who can provide in-home care services. We need to focus our attention on providing training and experience to people who can serve the Indian elders in their own homes before we begin thinking about nursing home placements.

There is also a tremendous need for the coordination of programs and the sharing of resources. Each program I have mentioned this morning probably has some speciality and resources, such as funding and/or manpower which could be better utilized if we could coordinate our efforts and share our resources.

Finally, we need advocates for the elders. Our individual program resources are limited, but each agency probably possesses certain unique resources, and we need advocates that will locate such resources.

Thank you for this opportunity to make this presentation.

[The prepared statement of Mr. Carr follows:]

STATEMENT OF ROBERT CARR, ALBUQUERQUE AREA DIRECTOR OF SOCIAL SERVICES, BUREAU OF INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR, BEFORE THE SENATE COMMITTEE ON AGING AT A FIELD HEARING ENTITLED, "CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS" IN SANTA FE, NEW MEXICO.

September 3, 1986

Mr. Chairman and members of the Committee. I am pleased to be here today to discuss with you the role of the Bureau of Indian Affairs and the health care of Indian elders.

I am the Director of the Social Services Program at the Albuquerque Area Office. My remarks, although specific to this area, are, I believe, representative of the Social Services programs throughout the Bureau.

The Albuquerque Area Office serves 23 tribes with approximately 48,150 people of which approximately 2,600 are over the age of 65. Our Social Services role in health care services for Indian elders is limited since the Indian Health Service is the primary Federal agency providing health care. We do provide financial assistance for custodial care, including assistance for in-home care services; direct social work service; and services resulting from the direct involvement of our agency social workers and tribal social services personnel in providing assistance to tribes in developing comprehensive health care services to their Indian elders. It is perhaps the non-financial services that are the most important of the Bureau's involvement with the health care services to the Indian elders.

Very briefly, the Bureau's services are as follows:

(1) Financial assistance: This assistance is limited to clients who are not eligible for any public assistance programs and can only be provided to Indian elders needing non-medical care and protection due to age, infirmity, physical or mental impairment, and those requiring care from others for his or her daily living. Because of the restrictiveness of

the eligibility factors, this makes up only a very small portion of the Albuquerque Area's financial assistance program.

(2) Direct social work services: Direct social work services to Indian elders include visiting them in their own homes or in nursing homes; assisting them with nursing home placements; helping their families to cope with the emotions and changes in roles brought about by out of home placements; and arranging for and helping Indian elders in applying for public assistance.

(3) Providing technical assistance to tribes: The Bureau Social Services personnel provides technical assistance to tribes in the development of comprehensive health and social services programs for their elders. These services are usually provided on an ad hoc basis and may include coordinating with other agencies for programs such as the Foster Grandparent or Handicapped programs. Those tribes who have established residential care centers for the elders know that caring for the older citizen is more than meeting their medical, shelter, safety, and nutritional needs. Comprehensive services to elders require that the meeting of social needs are as important to the overall health of the elders as meeting their basic needs. Our Social Services staff try to assist the tribes in meeting all these needs.

This concludes my prepared statement. I will be happy to answer any questions you may have.

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SOCIAL SERVICES

Senator BINGAMAN. Thank you very much. I appreciate it.

Mr. Bonner, our next witness, is with ACTION. Go right ahead, please.

STATEMENT OF DANIEL F. BONNER, WASHINGTON, DC, ASSOCIATE DIRECTOR, DOMESTIC AND ANTI-POVERTY PROGRAMS, ACTION

Mr. BONNER. Thank you very much. I am pleased to be here to represent the ACTION Agency. I would like to recognize Ernesto Ramos, who is the State director for the ACTION Agency, New Mexico. And as frequently happens the person who does the work is in the audience, and the person from Washington does the talking. That recognition is due, because we do have effective programs in the State of New Mexico.

Briefly as an overview, the ACTION Agency administers four major programs in the field of human services on a volunteer basis. That is, we value and promulgate the great contribution of the Americans as volunteers in helping other Americans. The first of the programs that I will mention is the VISTA Program, then I will mention three older American volunteer programs, the Retired Senior Volunteer Program, the Foster Grandparent Program, and the Senior Companion Program, the last of which I think has great application to the topic we are dealing with today.

The VISTA Program in fiscal year 1985 contributed over 2,000 volunteer service years to more than 500 communities around the country. Volunteers serve a broad variety of groups on each project site, and as of June 20, 1986, 57 VISTA volunteers were assigned to 11 Indian related projects. Sponsors include the South Carolina Council of Native Indians, the Small Tribes Organization of Western Washington, the Klamath Indian Tribe in Oregon, and the Mental Health of the Metlakatla Indian Community in Alaska.

Of particular interest to the citizens of New Mexico is the project sponsored by Save the Children, Inc., in Albuquerque. Volunteers are working with communities and tribal officials to provide affordable day care services; to train parents in the areas of early childhood development, health, nutrition, safety, traditional parenting practices, and children's activities; and to provide after-school, weekend, and summer activities for youth.

We are very pleased about the collaboration of the agency with Save the Children. We think that the name might be a trifle misleading. I think Save the Children understands that saving the children is a family affair, and entails as much the saving of the elder members of the family and helping them to become—and keep being—contributing members in the society as it does the working with and developing and nurturing of the young people themselves.

The other program that I want to mention in the interest of saving time, is the Senior Companion Program. Senior companions are seniors, people 60 and over, who receive a stipend. They're low-income individuals who receive a stipend for their services in working with other seniors who are in need. The great value of the program is that it helps seniors who are able to do so to remain contributing members of society, to work and to remain constructive, while helping others who are less able to help themselves. In recent years there has been a great interest, as we all know here, in cost containment of health costs. It makes sense therefore to consider the senior companion idea—or the principle—as a model. Not simply SCP projects that the agency runs, but to the extent possible those which States and other local governments can bring about.

The approximately 113 native Americans who serve on 5 SCP projects represent 2 percent of the total number of SCP volunteers in the program. Working through tribal health authorities and comprehensive health care plans, the companions provide inhome health services to some 300 older native Americans with chronic health conditions that limit their mobility. And the sponsors here are the All Indian Pueblo Council and the Zuni Pueblo.

Senior Companion Native American Programs were first organized in New Mexico in 1978. Fourteen pueblos receive companion service. On the average, the volunteers serve 2.5 homebound clients per week by providing information and referral services, respite care, household management, and so on. A comment was made earlier, and I think a valid one, too, that senior companions are serving more people than they do. It is not in the nature of the Senior Companion Program to stretch the valuable services of those seniors over much. By serving two people—or maybe a little more than that—on average per week, they enable other elders to stay out of institutions and to remain free or independent, which we all know is exceedingly important. The question, of course, however, is what could be done to help toward greater accessibility, visibility, and development of resources for senior companions. I think we all recognize that with the situation as it is in Washington, it's extremely difficult to bring about a great increase in dollars. But could other ways be found?

I will end it there. I just do want to underscore the importance, from the point of view of the ACTION Agency, of the Senior Companion Program is beyond doubt. Thank you very much.

[The prepared statement of Mr. Bonner follows:]

TESTIMONY
CONGRESSIONAL FIELD HEARING
DANIEL F. BONNER
ASSOCIATE DIRECTOR
DOMESTIC AND ANTI-POVERTY OPERATIONS
ACTION
SANTA FE, NEW MEXICO
SEPTEMBER 3, 1986

It is a pleasure to be with you today. I appreciate the opportunity to testify on the activities of ACTION, the federal agency responsible for volunteerism. The ACTION organization consists of headquarters in Washington, D.C., nine regional offices and 48 state or district offices. Our programs operate in all fifty states as well as Puerto Rico, the Virgin Islands and the District of Columbia. As the Associate Director for Domestic and Anti-poverty Operations I am primarily responsible for the administration of the Volunteers in Service to America, Foster Grandparent, Retired Senior Volunteer, and Senior Companion Programs.

More than 400,000 persons served as ACTION Volunteers in Fiscal Year 1985. If they had not been volunteers, their services to the nation would have cost $350,000,000, almost 150% more than the actual cost. The calculations, however, do not speak to the personal growth they experienced, or the improved quality of life experienced by those whom they served. Nor do they even begin to estimate the financial savings to society for each person who learns to read, gives up drugs, or leaves welfare for productive employment.

VOLUNTEERS IN SERVICE TO AMERICA (VISTA)

VISTA, is ACTION's oldest program. It was established in

1964 to alleviate poverty in America by assisting low-income individuals to become independent, self-sufficient, contributing members of our society. VISTA volunteers, about a third of whom are low-income, live and work full-time among the poor and are assigned to public and private non-profit organizations throughout the United States. The program awards funds, assigns volunteers, and shares technical assistance to strengthen community projects that offer citizens of all ages and all backgrounds the opportunity to share their skills with others.

More than half of the VISTA programs are youth oriented, addressing problems such as drug abuse, illiteracy, lack of job skills, runaways, and child abuse. Other volunteer activities include neighborhood revitalization, economic development, refugee settlement, and food banks.

In fiscal year 1985, VISTA contributed 2035 volunteer service years to more than 500 communities. Although volunteers serve a broad variety of groups on each project site, as of June 30, 1986 fifty-seven (57) VISTA Volunteers were assigned to eleven (11) Indian related projects. Sponsors include the South Carolina Council of Native Indians, the Small Tribes Organization of Western Washington, the Klamath Indian Tribe in Oregon, and the Mental Health of the Metlakatla Indian Community in Alaska.

Volunteer activities include a broad variety of efforts. Volunteers work under the sponsorship of the North Carolina Commission of Indian Affairs to increase participation in the health and human services delivery systems. Volunteers assigned to South Dakota Urban Indian Health, Inc. are developing a liaison between target community groups and local drug/alcohol treatment prevention services. VISTAs are similarly engaged in drug and alcohol related projects sponsored by the Sault Ste. Marie Tribe of Chippewa Indians in Michigan and the Mille Lacs Band of Chippewa Indians in Minnesota.

Of particular interest to the citizens of New Mexico is the project sponsored by Save the Children, Inc. in Albuquerque. Volunteers are working with communities and tribal officials to provide affordable day care services; to train parents in the areas of early childhood development, health, nutrition, safety, traditional parenting practices, and children's activities; and to provide after-school, weekend, and summer activities for youth.

OLDER AMERICAN VOLUNTEER PROGRAMS

ACTION's Older American Volunteer Programs offer men and women 60 and over the opportunity to apply their knowledge, maturity and caring where they are most needed. The three Older American Volunteer Programs - the Foster Grandparent Program, the Retired Senior Volunteer Program, and the Senior Companion Program - provide unparalleled experiences in personal development and satisfaction. We strongly believe that participation positively affects the physical and mental well-being of the volunteers.

FOSTER GRANDPARENT PROGRAM

The Foster Grandparent Program, since 1965, has matched low-income seniors with children who have special or exceptional needs. Foster Grandparent volunteers work in schools for mentally retarded, disturbed, and learning-disabled children; in Head Start Programs; in juvenile detention centers; in boarding schools and foster care homes; and in some cases in a child's home.

In 1985, some 19,000 volunteers contributed close to 20 million hours. Of this number, we estimate that 2.5% were Native Americans. Almost 430 Foster Grandparents serve on 13 projects in New Mexico. Twenty-five (25) serve here in Sante Fe.

Several of the Foster Grandparent sponsors are Native American organizations. In addition to the Zuni Pueblo, here in New Mexico, Native American sponsors include the Navajo tribe in Arizona where Foster Grandparent volunteers work daily with the children of the the Navajo Nation in Arizona. Utah. and New Mexico.

The Foster Grandparents sponsored by the Colville Confederate Tribes in Nespelem, Washington provide companionship. love and guidance to Indian children who have emotional and learning disabilities. Volunteer stations include Headstart and day care programs, high schools and Indian elementary schools. Other Foster Grandparents serve children in their homes under the supervision of the Tribal manager.

The Foster Grandparents who are assigned to the Great Lakes Inter-Tribal Council, Inc. at Lac du Flambeau, Wisconsin help native American children throughout the state in Headstart, day care centers and in the school system. Eight of the Foster Grandparents sponsored by the Big Horn Basin project in Wyoming are assigned to the Wind River Indian Reservation.

RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)

The Retired Senior Volunteer Program. initiated in 1971. is ACTION's largest program. It combines the interests and skills of seniors with rewarding part-time opportunities for service through non-profit organizations and local public agencies in more than one-fourth of the nation's counties.

There were 1 532 Native Americans serving as RSVP volunteers in 1985. The volunteers who serve at the Indian Hospital in Santa Fe provide friendly visiting services assist in the hospital pharmacy. help feed babies and provide clerical services. One volunteer travels each week from Santa Fe to the Cochitta Pueblo to serve as a receptionist at the Cochitta Pueblo Clinic.

Throughout the City of Albuquerque, Native American RSVP volunteers work at nutrition sites where they provide a variety of services including the delivery of food to the homebound, some of whom are elderly Native Americans.

The Director of the RSVP project in Wolf Point, Montana, has created an alcoholism support group for older Indians who live on or near the Fort Peck Reservation. Volunteers develop a sense of self-esteem through their work with other alcoholics and offer each other support in dealing with their own alcoholism.

Most of the 200 RSVP Volunteers with the RSVP project in Winnebago, Nebraska, are Native Americans who come from and serve the Winnebago, Santee Sioux, and Omaha Reservations. In the area of health care, the volunteers' services include transpor- tation from the reservations to clinics and doctors offices, assistance in filling out forms, support and encouragement of patients at the diabetic and blood pressure screening clinics and friendly visiting services to hospitals and nursing homes.

In Nevada, Indian RSVP volunteers train young as well as elderly Indians in physical fitness activities such as archery, boxing, and karate. Other volunteers on the same project offer referral information to elderly Indians regarding health services and medical insurance. The volunteers assigned to the Alcohol and Drug Abuse Rehabilitation Center provide services to a broad range of clientele including Indians. Volunteers who assist in the Commodity Food Program distribute food to elderly Indians on and off Reservations.

RSVP volunteers feed and counsel elderly Indians at the Phoenix Indian Medical Center in Arizona and at the Senior Center of the St. Regis Indian Reservation in Malone. New York. Native American volunteers in Wisconsin work with youth in schools and in drug abuse prevention programs. Several of the volunteers on the Ah-Gwah-Ching in Minnesota serve at a senior nutrition site on the Leech Lake Reservation.

SENIOR COMPANION PROGRAM (SCP)

Since 1974, low-income Senior Companions have helped thousands of their peers gain the confidence and positive mental attitude needed for successful independent living.

The Senior Companion program is one option to provide alternative long-term care in the face of rapidly escalating costs. The program's strength is its capacity to provide one-to-one personal support to the homebound older person at risk of inappropriate institutionalization. The home care services by a Senior Companion, specially trained in personal care, nutrition, home management. and information and personal representation - and working within the framework of a professionally developed plan, - augment professional and paraprofessional services, allowing the client to maintain his or her independence at home.

The approximately 113 Native Americans, who serve on five (5) SCP projects, represent 2 percent of the total number of SCP Volunteers in the Program. Working through tribal health authorities and comprehensive health care plans, the Companions provide in-home health services to some 300 Older Native Americans with chronic health conditions that limit their mobility.

Senior Companion Native American programs were first organized in New Mexico in 1978. Fourteen pueblos receive Companion services. On the average, the volunteers serve 2.5 homebound clients per week by providing information and referral services, respite care, household management. transportation to medical services. alcohol abuse treatment, and acute care hospital discharge support services. The state legislature appropriated an additional $25,000 specifically to support seven Native American Senior Companions. The funds are channeled through the State Office on Aging to the All Indian Pueblo Council SCP.

In Arizona, the Flagstaff SCP, operates an all-Indian volunteer station on the Hopi Reservation which recently conducted its first 40 hour health care orientation training on the reservation. It was attended by seven tribal health care aides. Staff also prepared the first comprehensive health and social service resource guide for older persons.

Throughout Alaska, Senior Companions provide respite care to middle age women who traditionally remain at home to care for frail elderly relatives. Senior Companions make it possible for these women to work outside the home, thus considerably reducing welfare dependency.

COORDINATION OF EFFORTS WITH OTHER FEDERAL AGENCIES

ACTION, mandated by Congress to coordinate its activities with other federal agencies, negotiates interagency agreements to expand services through the deployment of volunteers in a manner consistent with the Administration's emphasis on budget austerity.

ACTION is currently working with the Department of Health and Human Services to develop long range health care alternatives for the elderly that leverage federal health care dollars to the fullest extent possible.

SELF-SUFFICIENCY

Supporting projects to become self-sufficient is one of ACTION's major objectives. As a nation, we have learned that we cannot create programs that wither away when federal funding ends. ACTION encourages community organizations' efforts to get off the ground or to explore new terrain in a manner that enables them to demonstrate their viability to local funding sources.

ACTION's focus is local - local independence, local inqenuity - local citizens applying local solutions to local problems. ACTION encourages citizens to take responsibility for making a difference through locally devised and controlled voluntary efforts.

Senator BINGAMAN. Thank you very much. I appreciate it.
Mr. Mecham, if you will please proceed.

STATEMENT OF RAFAEL MECHAM, PHOENIX, AZ, DIRECTOR, OFFICE OF INDIAN PROGRAMS, HUD

Mr. MECHAM. Mr. Chairman, I appreciate this opportunity to participate in this hearing. And I am honored to represent the Department of Housing and Urban Development here today. Before I discuss the older Indian population as a specific segment of housing demand and supply on Indian reservations, it may be helpful to give an overview of HUD programs that are currently available to Indians.

We administer four major programs in the Indian community; the Lower Income Indian Housing Rental Program; the Home Ownership Opportunity Program, which includes Mutual Help and Turnkey III; and the Community Development Block Grant Program for Indian tribes and Alaska Native villages; and the Urban Development Action Grant Program.

HUD's Indian programs are administered through six Indian field offices nationwide.

As you know, the Department's Indian programs for housing and community development are administered in the context of special needs and circumstances imposed by Indian trust land restrictions, the diverse and complex historical and cultural patterns of Indian and Alaska Native life, and the special legal and historical relationships between the Federal Government and Indian tribes. The design of HUD's current Indian programs reflects a continuing effort to achieve delivery systems that are responsive to the special housing and community development requirements of Indian and Alaska Native communities.

The Department delivers housing services through 170 Indian housing authorities, which have developed and now manage the approximately 54,000 housing units built since inception of the program in the early sixties. Our most recent data indicate that more than 20 percent of these homes are now occupied by families termed "elderly," although this designation refers more to age of the "head of household" than to all the occupants of a given unit. Only about 5 percent of the total Indian housing inventory was constructed for exclusive occupancy by the elderly.

Indian communities are also eligible for the section 202 program. However, the 202 program is not feasible in many smaller Indian communities because the necessary nonprofit sponsors are in short supply.

In a considerable number of projects, Indian elders live with their families under a single roof which is consistent with the cultural values of those Indian communities. This tradition helps explain the relatively small proportion of units designed and constructed specifically for elderly occupancy. That is because, in ranking local housing needs, Indian officials recognize the acceptability—if not preferability--in shared living arrangements. As a consequence, they focus on the need for housing families, of which elderly are an integral part, rather than on the elderly as a special grouping.

Some Indian tribes obviously do see their elderly as a unique grouping, and there are some good examples of Indian housing targeted to the elderly in every Indian region.

In the Midwest near Duluth, MN, the Fond Du Lac Indian Housing Authority is developing a 15-unit elderly multiplex, located near a medical clinic. The Chicksaw Indian Housing Authority recently built a high-rise complex for seniors in Ardmore, OK. The Laguna Rainbow Project, which we heard about this morning, in nearby Laguna Pueblo, NM, has a 20-bed nursing home and a 40-unit congregate housing facility. Specialized services are provided to residents using funds from HUD's Congregate Services Program.

In Anchorage, AK, the Cook Inlet Housing Authority has already developed 2 projects of 60 units funded at the rate of 60 percent by the State of Alaska and the rest through HUD's Indian Housing Program. This Indian Housing Authority is also constructing an intermediate care facility of 78 units which will allow support services for frail elderly persons. The services are transportation, a nutrition program for meals, personal care, and medication as required by the individuals. Coordination with the Indian Health Service for these elderly projects also occurs at the local level.

It is our job at HUD to support, and to encourage and advise local tribes in meeting the needs and goals which only they can adequately determine for themselves. Where the elderly or even special groups among the elderly, are identified as priority by the local tribe, we will be as responsive as possible to that local reality. Where the tribe sees simply housing, which may or may not be occupied by elderly households or elderly family members, as the top need, that preference must be equally honored.

This concludes my prepared remarks.

Senator BINGAMAN. Thank you very much. I appreciate that.

Mr. Gene Dickey, who is with the Department of Agriculture. Mr. Dickey, thank you for being here.

STATEMENT OF GENE DICKEY, DALLAS, TX, REGIONAL ADMINISTRATOR, FOOD AND NUTRITION SERVICES, U.S. DEPARTMENT OF AGRICULTURE

Mr. DICKEY. Senator, thank you very much. It's good to be here again, Senator. I thank you for the opportunity to explain some of our programs to this very special group.

My agency operates 13 food programs, and there are 4 of them that are of special interest I think to Indians and specifically elderly Indians. I'd like to give an overview within the time alloted this afternoon of those four programs. I'd like to say that most of those programs—as a matter of fact, three of the four—are administered by various State agencies; and I would like to recognize Jane Cotter, who is involved in administering the Food Stamp Program here in New Mexico at the Department of Human Services. And I also want to acknowledge two of my staff, Judy Snow, Public Affairs Office, and Les Berry, here. And the reason I want to do this is, as I describe the programs or mention the programs, we have information on them and contacts within the State should the individuals run into complications or, not being participants in the program, information from a sponsor or participant point of view.

First of all, let me mention the four programs that I spoke about. One is the Food Stamp Program. While not targeted to this particular population, it is of importance to the population. It's very large. Nineteen million people a day participate in the program. But if you look at my prepared testimony, you will see that not many of those are elderly Indians, a very small number.

Another program is what we call the Food Distribution Program on Indian Reservations. Another one is a distribution program that is above and beyond the one on Indian reservations, and the last one is the Nutritional Program for the Elderly, which is in conjunction with the Office of Aging. We do not administer the program, but we do supply some money or commodities to that program which is administered by the Office of Aging.

Let me talk about the Food Stamp Program, the first program I mentioned. I'm sure most of you know what the Food Stamp Program is. Basically, it's a household feeding program designed to assist low-income households to purchase food. In this State, it is administered by the Department of Human Services. State employees at certification centers throughout the State render the certification. Benefits are determined based upon that certification and the food stamps are issued to the clients and they, in turn, purchase food at the various grocery stores or outlets for food throughout the State. I won't get into detail on the program. Like I say, that's conceptually the way it works.

Now, another program is the Food Distribution Program, which is administered on the Indian reservations or Indian lands. That is a program authorized by the Congress in lieu of the Food Stamp Program. It's designed specifically for Indian nations. In New Mexico, there are such operations on four reservations. The way that program works is the tribal government, so long as it's a federally recognized tribe and the reservation boundaries are recognized, makes application for the program basically to our field office, Mr. Berry's office in Albuquerque, and we have that address for the attendees. Once they're accepted and their operating budget is approved, there is a matching requirement of 25 percent of the program for administrative costs. The commodities then are delivered through a recipient certification process to clients just as in the Food Stamp Program. It's very important, however, that clients by law cannot participate in both the Food Stamp Program and this commodities program. This program is designed particularly for that clientele.

The nutrition program for the elderly, as I said is not administered by FNS. The Congress has authorized commodities, as I mentioned, as a component of that program. Congress also authorized States to make the decision to take money in lieu of commodities if they desire. And in New Mexico that is the choice that has been made, and approximately 55 cents per meal is transferred directly to the office on aging in the State, and then that money is passed to the local providers in the nutrition program for the elderly. And it is strictly, from our point of view, a passthrough issue to the office on aging. But I did want to mention that.

There is another commodity program that I want to mention because you may not be aware of it and it may be used in areas that are now underserved. It is also administered by the Department of

Human Services in New Mexico. It came about under emergency legislation about 3 years ago. You will recall we were very concerned at that time with the economy and a lot of provisions were tied to the temporary employment program. One of these was a temporary foods assistance program, which is designed for household feeding. It carries with it basic staple items, foods such as cheese and butter, heavy on dairy products, honey. There are 70 of those operations in New Mexico. While it's not specifically targeted to the Indian population, it has definite potential there. And I would like to direct your attention to that program as well, particularly for underserved areas or those not being reached by the commodity program.

Senator, that gives basically an overview of our four programs that I think are relevant to population. I want to thank you again for the opportunity to be here.

[The prepared statement of Mr. Dickey follows:]

TESTIMONY OF GENE P. DICKEY
REGIONAL ADMINISTRATOR
SOUTHWEST REGIONAL OFFICE
FOOD AND NUTRITION SERVICE
U.S. DEPARTMENT OF AGRICULTURE
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
SANTA FE, NEW MEXICO
SEPTEMBER 3, 1986

Thank you for your invitation to appear in Santa Fe, Senator Bingaman, to discuss the role played by the United States Department of Agriculture (USDA) in contributing to the nutritional well-being of elderly Indians. I am pleased to be a part of this field hearing and will attempt to describe our efforts in this area.

The principal arm of USDA which provides nutritional services is my agency, the Food and Nutrition Service (FNS). It administers thirteen programs providing food and nutrition assistance to populations ranging from pregnant women and infants to school-age children to persons in charitable institutions to reservation Indians to those simply with low incomes. Four of these programs have special significance for elderly Indians: the Food Stamp Program, the Food Distribution Program on Indian Reservations, the Nutrition Program for the Elderly, and the Temporary Emergency Food Assistance Program.

Food Stamps and Elderly Indians

The Food Stamp Program is a nationwide program which helps low-income people purchase more nutritious diets. Assistance is provided in the form of coupons that can be redeemed for food at over 230,000 authorized grocery stores and other outlets. The program is administered at the Federal level by the Food and Nutrition Service and at the State and local levels by State or county social service departments. These social service departments use federal standards to determine the eligibility and benefit levels of applicants and issue benefits monthly.

Families and individuals may be eligible if their monthly income and resources are low, and they meet a limited number of nonfinancial criteria. Benefit levels are based on household size and income available for purchasing food after other expenses are considered. For the period October, 1985, through September, 1986, an individual living alone may receive up to $80 a month, a two-person household up to $147 a month, and a four-person household up to $268 a month. The program served about 19.9 million people monthly at a cost of $11.7 billion during Fiscal Year 1985. Approximately 316,000 Indians participate in the Food Stamp Program. Of this number it is estimated that approximately 15,000 are elderly.

The Food Stamp Program contains special provisions to address the needs of the elderly, that is, persons age 60 or over. These provisions include the following:

- _Net Income Test_. Households without elderly or disabled persons have their eligibility based on their gross and net incomes and their level of benefits on their net income after the allowable deductions are subtracted. By contrast, households with elderly or disabled members have their eligibility based on the net income amount alone.

- _Joint Processing_. Elderly persons can apply for food stamps at local social security offices at the time they apply for Supplemental Security Income (SSI) benefits.

- _Medical Deductions_. Households with a member who is 60 or older may deduct all medical expenses that exceed $35 a month for its elderly or disabled persons.

- _Shelter Deductions_. Food stamp rules permit households with elderly or disabled persons to deduct all shelter costs over 50 percent of the household's adjusted income. Households without elderly or disabled persons have limited shelter deductions.

- Higher Allowable Assets. The Food Stamp Program allows households with at least one elderly member to have up to $3,000 in assets and remain eligible. All other households are allowed $2,000.

- Dependent Care Deductions For Working Adults. Food stamp households may deduct up to $147 per month for the care of an elderly or disabled person when such care enables a household member to accept or continue employment, or to participate in training or education preparatory to employment.

- Work Registration Exemption. The elderly are exempt from the program's work registration as well as the other work requirements, such as Job Search.

- Monthly Reporting Exemption. Elderly persons who have no earned income and who live alone or with others all of whom are elderly or disabled and have no earned income are not required to file reports under periodic reporting/retrospective accounting systems.

- Household Definition. Elderly parents or siblings are exempt from the requirement that parents and children or siblings who live together must be considered as one household for food stamp application purposes. In addition, those elderly persons who live with others of moderate income and who are unable to prepare their own meals because of ill health may be certified separately from those with whom they live.

- Congregate Dining Facilities and Home Delivery of Meals. USDA may authorize non-profit food service programs to accept food stamps from the elderly and disabled in payment for meals. Such food service programs may include congregate dining facilities and services that deliver meals to homes.

  In addition, States may contract with restaurants to offer meals at low or reduced prices to elderly food stamp participants. When approved by USDA, such restaurants may accept food stamps for meals.

Food Distribution Program On Indian Reservations

One of USDA's oldest food programs, the Needy Family Program was established in 1936 as a State-administered Commodity Distribution Program. Eventually Indian Tribal Organizations (ITOs) began entering into direct agreements with the USDA for administering the program on Indian reservations.

By 1974, the spread of the Food Stamp Program in all States and some territories meant that the Needy Family Program was all but eliminated.

The Food Distribution Program on Indian Reservations (FDPIR) was created by Congress in the 1977 Food Stamp Act as a replacement of the Needy Family Program for Indian reservations. The program offers commodities in lieu of food stamps for low income Indian households living on or near reservations. This food distribution program represents an alternative to the Food Stamp Program for Indian households living in rural areas where the Food Stamp Program is not available, or where food stores are inconveniently located. No household may participate simultaneously in both FDPIR and the Food Stamp Program but eligible households can switch from one program to the other. ITOs are encouraged to administer the program at the local level. FNS provides administrative grants directly to ITOs to permit them to operate the program.

The food package offered each month provides participants with the opportunity to obtain a more nutritious diet. FDPIR uses surplus foods produced by the American farmer as well as foods purchased specifically for use in FDPIR. Indian household food preferences are taken into consideration in the design of the food package. Eligibility and participation for FDPIR are based on application and certification requiring reservation or tribal status, income and resource qualifications and related nonfinancial factors. Approximately 144,000 persons per month participate in FDPIR. While we do not collect data on the number of elderly Indians participating in the FDPIR, we estimate it would be approximately 5 percent, the same percentage as participate in the Food Stamp Program.

Since 1979, the program has grown from four ITOs to 81 ITOs and five States administering the program for 194 Indian reservations in Fiscal Year 1986.

Nutrition Program for the Elderly (NPE)

The Nutrition Program for the Elderly, donates foods and cash in lieu of foods to help meet the nutritional needs of elderly Indians through two separate programs, Title III grants for State and Community Programs on Aging and Title VI, Grants for Indian tribes. Both programs subsidize meals and are administered through the U.S. Department of Health and Human Services (HHS). Title III of the Older Americans Act of 1965, as amended, provides nutritious meals for all elderly citizens without regard to their financial circumstances. Title VI was added to the Older Americans Act in 1978 to permit ITOs to operate their own elderly nutrition programs. In both programs HHS gives grants to State Agencies on Aging, which designate Area Agencies on Aging (AAA), or contracts directly with ITOs to plan and coordinate the nutrition program through providers of nutrition service at the local level. Approximately 38,000 American Indians or native Alaskans participated in the Title III program in Fiscal Year 1985. Almost 18,000 Indians received subsidized meals through Title VI the same year.

The State Agencies on Aging or ITOs receive cash, donated food, or a combination of both to provide meals to elderly Indians at various sites. The amount of food or cash that USDA gives each State or ITO is based on the number of meals served in the program and the level of appropriations. Initially, USDA support for the program was provided in donated foods. This aided USDA with its price support and surplus removal activities as well as provided direct support for the meals served in the program. However, once legislation authorized cash in lieu of donated foods, the program increasingly became a cash transfer program. In fact, currently all USDA support for meals in this program in New Mexico is provided in the form of cash.

This past June, the Department announced a change in policy with respect to the availability of bonus commodities to the Elderly Feeding Program. Bonus commodities are those surplus commodities which the Department offers to a State or ITO at no cost for use in feeding programs. Previously, only States or ITOs electing to receive 50 percent of their Elderly Feeding Program support in the form of commodities were eligible to receive bonus commodties other than dairy products. Dairy products may be ordered by any State. Under the new policy, if a State or ITO agrees to take just 20 percent of its Elderly Feeding Program support in the form of commodities, it may order in addition to dairy products, commodities such as ground and canned beef or flour over and above the support level taken in commodities. Sometimes surplus fruit, vegetable and poultry items also are available over and above support level quantities. Research has indicated that by taking advantage of the vast purchasing power of the Department, local program operators can augment the value of their Elderly Feeding Program support through expanded commodity usage. For our part we are working with our state distributing agencies to try to encourage Elderly Feeding Programs to take greater advantage of USDA commodities.

The elderly Indian nutrition services are provided in schools, community centers, churches, public housing, and other places accessible to the majority of local elderly Indians. By statute, the AAA or ITO provides nutritious, well-balanced meals at least once a day, 5 or more days a week. The AAA or ITO will also provide transportation to and from the sites for those who need it, when possible. Similarly, the AAA or ITO will provide home-delivered meals at least once a day, 5 or more days a week, when possible, to older Indians who are homebound.

Persons 60 years of age or older and their spouses, regardless of age, may participate in the program. The Nutrition

Program for the Elderly is not means tested. Tribal organizations representing Indians age 60 or older are eligible to operate their own programs. However, each person is provided the opportunity to contribute toward the cost of the meal. Meals are provided free of charge to eligible persons.

Food Distribution for Elderly Indians

Additionally, the USDA offers food assistance to elderly Indians through the Food Distribution Program for charitable institutions (e.g., soup kitchens and nursing homes). Elderly Indians may also receive available surplus food through the Temporary Emergency Food Assistance Program. These two programs do not restrict any recipient from participating based upon age; economic need is the only requirement.

The Temporary Emergency Food Assistance Program (TEFAP) gives needy Americans, including low-income and unemployed persons, USDA-donated foods for households use. The foods are free but recipients must meet certain eligibility criteria. A temporary program, TEFAP is authorized by Title II of Public Law 98-8, as amended (the Temporary Emergency Food Assistance Act of 1983).

Food distributed by TEFAP has been declared surplus after certain other commitments have been met by USDA. Currently cheese, butter, nonfat dry milk, corn meal, flour, rice and honey are distributed through TEFAP. USDA provides these foods in package sizes that are suitable for household use.

In each State, USDA enters into agreements with the agency responsible for administering the program. The State agency selects public or nonprofit emergency feeding organizations such as food banks and delivers the foods to them. These organizations then distribute the food to needy persons.

Besides buying the food, processing and packaging it, and shipping it to the States, USDA also provides funds to State agencies to help defray costs incurred by them or by local organizations. These funds may be used to store and distribute the food. At least 20 percent of these funds must be reserved for use by the local feeding organizations to help meet their costs in giving the food to needy persons.

During Fiscal Year 1985, USDA made a total of over 934 million pounds of surplus foods available to States for distribution to needy households. New Mexico received 7,049,372 pounds of food at a total cost of $7,535,111. Since the beginning of TEFAP, New Mexico has received 25,640,388 pounds of food at a cost of $28,916,439. For the entire U.S., the amount of surplus food and its value since TEFAP began is 3,463,881,419 pounds at a cost of $3,897,846,042.

Coordination with other Federal Agencies

Due to the magnitude of effort by USDA to provide nutrition assistance to Indians, coordination with other Federal agencies in providing services is essential. Whenever possible, USDA cooperates with DHHS in its efforts to serve the Indian population.

Recently, the Indian Health Service (IHS) worked with USDA in revising and upgrading the food package and nutrition education services provided in the FDPIR. We shall continue to rely heavily on the IHS for future consultations of this nature.

In addition, USDA works closely with Aid to Family with Dependent Children and the Social Security Administration in determining food stamp eligibility and verification.

In conclusion, Senator Bingaman, USDA is committed to making certain that the nutritional needs of elderly Indians are adequately met. We have in place several programs to respond to these needs, and believe we are doing a good job.

That concludes my prepared testimony. I shall be glad to try and answer any questions.

Senator **Bingaman**. Thank you very much for the testimony.

Let me just ask a few questions here. I guess the first overall question I would like to ask of any member of the panel, starting with Mr. Buzzard, is this point that was made earlier—I think Mr. Cook made it first and then several others concurred—that there is a real lack of coordination among Federal agencies to ensure a continuum of health care for Indian elderly. That something in the nature of a—I don't know if it would be an interagency task force or some other kind of coordinating mechanism that might improve the situation. I would be interested in anyone's reaction if there is such a mechanism in place. If the problem exists and if it does exist, what should we do about it.

Mr. **Buzzard**. I would be the last person to say the problem doesn't exist. I think it's been handled several different ways in the past. The Administration on Native Americans had an interdepartmental council of Indian affairs or something like that at one point where that group was supposedly coordinating all services in the Federal sector. Indian Health Service was a member of that committee. But I don't know whatever happened. I do know there has been attempts to try to coordinate services. It is a problem. I don't know how to answer that question.

Senator **Bingaman**. Do any other members of the panel have further comments? Mr. Bonner.

Mr. **Bonner**. Just one briefly. I am a member of an intergovernmental task group that meets monthly to discuss the problems of persons with disabilities. It's been running now since 1981 with this much success, that because of the driving force of the persons who chair the group, it has continued to meet and to invite proper heads of Government, of the U.S. Government, various departments, also private sector organizations like Rehabilitation International and so forth. I couldn't say it has done a tremendous amount of work or has accomplished a tremendous amount. But it is a start. It is a point of coordination for discussing issues. I just don't know whether such a task group could be set up in Washington to address the issue before us, but I simply mention it here because that's one thing I do know about.

Senator **Bingaman**. At what level does this group operate?

Mr. **Bonner**. These are persons recruited by secretaries of departments and heads or directors of other agencies. It turns out they've tried to get as many ranking people as possible. Not all of them are career civil servants. Some of them are appointees. And there are about 20 agencies that meet regularly. If I say fairly high level that is not too descriptive. They are recruited by the heads.

Senator **Bingaman**. These are aimed at people with disabilities?

Mr. **Bonner**. Correct.

Senator **Bingaman**. It does not address the problem we're concerned with here today?

Mr. **Bonner**. No, Senator, it does not. I mention it as exemplary only.

Senator **Bingaman**. Thank you very much. Yes, Mr. Carr.

Mr. **Carr**. Earlier in someone's testimony they spoke about the need for a statewide coordinating body. To establish meaningful priorities or to establish program and services on the reservations, in the Albuquerque area for example, All-Indian Pueblo Council or the New Mexico Indian Affairs Commission could act as that coordinating body. They could possibly be more successful in getting the Federal agencies to respond and to work together. Either body could possibly get the Federal and State agencies to better coordinate their services and sharing their resources.

Senator **Bingaman**. Yes, Doctor.

Dr. **Tempest**. I guess I have a somewhat different point of view, since I spend most of my days and a lot of nights taking care of the patients. My response is at a different level, which is what we do. That simply is twice a week we sit down, physicians who I work with, an alcohol worker who comes through a private organization, a social worker, a Navajo nurse who is a planning—who arranges discharge planning things. And we try to coordinate these things among the local agencies, and it is a problem. I think taking care of the patients in the hospital, in the clinics and things we have adequate resources to do that, the medical problems. And the difficulty that we spend most of our time working around is how are we going to get transportation back to the clinics? How are we going to provide nursing care in the home? And how are we going to continue with health education things?

So I think coordination at a higher level, I can't address that. I'm telling how we have to deal with it locally.

Senator **Bingaman**. So I guess what I am hearing is the problem can't be solved by setting up some mechanism for coordination at one level or another. It probably has to be at all the different levels, maybe in Washington, maybe at the State level, maybe at the local level; and there has to be some sort of continuing coordination at all those levels; is that right?

Dr. **Tempest**. Very much so. The individual patient to be taken care of, it really has to be down to the very local level.

Senator **Bingaman**. To what extent is it realistic or helpful to think about a written policy statement which would define the responsibilities of various agencies at one or more of these levels for this continuum of health care? Is it worth considering—for some group of representatives from each of the agencies involved—to sit down and try and come up with a written statement about how to meet these needs and identify where the gaps are? Does that make sense?

Dr. **Tempest**. I guess I'm somewhat pessimistic about that. Having been around the Navajo for 20 years, things keep changing, programs keep changing. I think that's good, and the problem is, you write something down like this, it changes in a few weeks. I think a lot of really getting patients cared for is really interaction among people. You kind of establish peoples' realm of function.

Senator **Bingaman**. So your thought is a mechanism for continuing coordination is much more important than any attempt to come to some kind of definitive agreement about who is responsible and who has authority?

Dr. **Tempest**. I think in very broad levels that's probably worth while. But I think for the specific day-to-day function, a lot has to do with just getting together with people as we do, just planning discharges and things.

Senator **Bingaman**. Do any of the others have a comment on that?

Mr. MECHAM. An illustrative example might be the housing delivery program. It would be impossible to deliver the product if we didn't have a coordinated and very complex written document with the BIA, IHS, and HUD. To a lesser degree, the same is true with our block grant program where we also coordinate very closely with IHS to provide grants that in some ways and sometimes do contribute to the very subject matter of today's hearing. I'm of the opinion that a coordinated effort, even it has to be reduced to writing, is probably the only way anything significant will ever be coordinated among the agencies.

Senator BINGAMAN. Are you also generally in agreement with Mr. Carr's suggestion that the sort of impetus for this coordination should come from, for example, the All-Indian Pueblo Council or a State agency? Is that what I understood you to say, Mr. Carr?

Mr. CARR. I was using them as examples of statewide bodies that dealt with and who worked with all the tribes in the State.

Senator BINGAMAN. Does that make more sense rather than having one of the Federal agencies to be the lead agency on it? Does anybody have any thoughts on that as to who is the logical person to take the initiative to do this?

Mr. DICKEY. Senator, I'm kind of on the outside of this conversation, but it seems to me that it depends on where the Federal flow of assistance goes—whether it goes through a State agency or directly to the Indian tribe. You have a different set of scenarios, I think, under those circumstances. I would suggest it might make some sense to categorize the grants and assistance into two or three different groups and then have three or four approaches, all of which have some merit in some circumstances. We've had some experience, which has been very successful with the Bureau of Indian Affairs in our school lunch program, with an interagency agreement involving a transfer of funds. But there was a reason to do that at a national level because the State wasn't involved. And that would be an approach that I would recommend.

Senator BINGAMAN. Anybody else have a comment on that? Or else I will switch to another question.

Let me ask again, Mr. Buzzard—you or Dr. Tempest may answer—in the Indian Health Service testimony it mentions a geriatric health coordinator position that exists in one of your IHS service areas. Can you tell me which area this is and whether it makes sense to expand that idea IHS-wide? We're not talking about Albuquerque are we?

Mr. BUZZARD. It's in the Aberdeen area.

Senator BINGAMAN. Aberdeen?

Mr. BUZZARD. Yes. It's Rapid City.

Senator BINGAMAN. Is there a reason why such a position shouldn't be here in Albuquerque?

Mr. BUZZARD. No, there isn't. Albuquerque area I think has had—has been fortunate within the Indian Health Service to have a social worker that has great interest in aging activities and has more or less coordinated most of the aging activities in Albuquerque. But I think given the trend and the number of aging people that are going to be here with us in the next few years, we should be developing some kind of plans to address those issues when they're here.

I think Indian Health Service at this point does have the authority to—rather than develop a policy statement about the elderly, it already has the authority to administer an aging problem. On the other hand, when you're looking at only 5.3 percent of the population, the Director of the Indian Health Service has to make a decision at some point where he's going to administer those funds. Again it goes back to priorities.

Senator BINGAMAN. But I guess what I hear you saying is that with the changes in the demographics of the Indian population, you would see the trend toward setting up a position of geriatrics health coordinator as continuing?

Mr. BUZZARD. Yes.

Senator BINGAMAN. You would expect that to happen in the Albuquerque area and your other areas?

Mr. BUZZARD. Yes.

Senator BINGAMAN. Let me ask Mr. Mecham, if I could, the Laguna Rainbow Corp. has had some success in working with HUD in getting some housing built. To what extent do you think there is additional opportunity for other tribes and pueblos to follow that same model and get assistance through your agency?

Mr. MECHAM. I think the opportunity is very real. The significant drawback of this is it's administered and funded through one pot of money. In other words, there is no special funding for the housing units that are constructed specifically for elderly people. This special housing need will draw down against the total nationwide allocation for Indian housing units.

However, if a specific housing authority and their tribe wish to make an application, and defer other housing specifically for the needs of the elderly people, we would be amicably disposed to honoring that request, inasmuch as we have funds to do so.

Senator BINGAMAN. Let me ask Mr. Dickey, if I could, you indicated about 70 food distribution centers here in the State under the Commodity Distribution Program. How many of those 70 centers are on Indian reservations or pueblos to the best of your knowledge?

Mr. DICKEY. Senator, I don't know the answer to that. I can get it for you. Les, do you know the answer to that?

Mr. BERRY. I don't know the answer to that.

Mr. DICKEY. I don't believe any.

Mr. BERRY. I don't think we have any on Indian reservations.

Mr. DICKEY. I don't think so. I could be wrong about that, but there aren't many.

Senator BINGAMAN. Is there a reason that escapes me that I didn't follow in your testimony why we should not pursue the establishment of that—those kinds of centers on Indian land?

Mr. DICKEY. There isn't—you did not miss a point. There are 70. The State's position, I believe, is that they want the State served and, if these 70 that exist are underserving or not serving at all, I'm sure they would be favorable to correcting that.

Senator BINGAMAN. If there is a particular tribe or pueblo that feels that they have a group of elderly that are not being served and could be served by this program, what process would they follow? What procedure in order to get one of these centers on their pueblo or reservation?

Mr. DICKEY. They should contact New Mexico Human Services Department, the Commodity Bureau, and I have the address. It's in Albuquerque. Post Office Box 1968. I can give it to your staff or any members here. Also Mr. Berry will be glad to help with the State on that. A lot of those programs are likely serving the Indians. You do understand that. I do want to point that out. I think most of them are not sponsored by local Indian reservations. That is a point that should be pursued, yes, sir.

Senator BINGAMAN. This is being carried out under legislation that was passed 3 or 4 years ago?

Mr. DICKEY. That's correct.

Senator BINGAMAN. That may be one reason why Indian tribes or pueblos have not——

Mr. DICKEY. That could be.

Senator BINGAMAN. It's a fairly new program?

Mr. DICKEY. Yes, it is. There is another point to that. There are two dimensions of that program. One is the commodities. Commodities of course, are in abundant supply, as a matter of fact. There are more of the staple items than in some of the other programs. There is an administrative dimension also. Administrative cost is a single grant which has to be justified by the sponsor. My point is that there is a limited amount of administrative money but we can by most standards say that there is not a limited amount of commodities. That program is also for low income households and the State has criteria for that.

Senator BINGAMAN. Of the USDA programs that you mentioned in your testimony, are they adequately used by the Indian population at this time?

Mr. DICKEY. One looks at the food stamp data, and the Indian population is not unique to other populations. That isn't just in New Mexico. That's nationwide. If you look at the poverty data nationwide and compare it to the participation in the Food Stamp Program, you will see there is a disparity in those numbers. So one can conclude there are some people who are not taking advantage of the Food Stamp Program. That's also true in the Indian population, and it's specifically true for the Indian elderly population we think. There are lot of reasons for that—the location, perhaps a lot of barriers. I know the State tries very hard to deal with some of the barriers in terms of certification processes, communication issue. They try very hard to eliminate those barriers. Perhaps that is an area that could use some attention.

Whether to use the other commodity program that is available instead of the Food Stamp Program is merely an issue that tribal government has to take up and decide. Do they have adequate population to support a food distribution program. I would say that most of the tribes have to look at that pretty carefully from an economic point of view.

Senator BINGAMAN. Did you say there were four of these operations on four separate reservations where they actually have food distribution programs in lieu of the food stamp? Is that what I understood you to say?

Mr. DICKEY. Yes, sir, that is what I said.

Senator BINGAMAN. Do you know offhand or is it reasonable to tell us which of the four do have that?

Mr. **Dickey**. Five Sandoval, Zuni, Eight Northern Pueblos, and Pueblo of Acoma.

Senator **Bingaman**. Sandoval—which ones now?

Mr. **Dickey**. Eight Northern.

Senator **Bingaman**. What was the first one?

Mr. **Dickey**. Zuni, Five Sandoval, Eight Northern, Pueblo of Acoma are the four. Now, those tribal governments have made the decision to have this household feeding program. They make application to the FNS office in Albuquerque. And there is a matching requirement of 25 percent of the administrative costs. The certification process of the clients is very similar to the Food Stamp Program. Clients cannot participate in both programs simultaneously. They can't switch back and forth during a specific certification period.

Senator **Bingaman**. Is it fair to say—as I gathered from your comments on the food stamp issue—that although there may be a great many people in poverty who are not taking advantage of food stamps nationwide, the percentage of those in poverty who are not taking advantage of food stamps among the Indian population is substantially greater than the percentage of the overall population who are in poverty and not enrolled in food stamps?

Mr. **Dickey**. I haven't analyzed those data, Senator. My first impression is that is true for elderly Indians.

But by the same token, you've got a much better developed food distribution program, I think, and other programs from a nutritional point of view on the Indian reservation than the other population. That is, you don't have the food distribution delivery system in the rest of the population that you do on many of the reservations.

In analyzing that data, you would have to put that all down again.

Senator **Bingaman**. Let me just ask Mr. Buzzard if he or Dr. Tempest would comment on the testimony this morning which essentially said that there is a very large unmet need for home health care among Indian elderly. And if that need does exist, what can be done to deal with it?

Mr. **Buzzard**. I think that there is a need that exists out there. And again, it's the isolation, where the people live. I don't know how effective our community health nursing program is in providing those kinds of services. We have advocated for home health care. We do provide those kinds of services. How adequate that is, I don't know.

Senator **Bingaman**. I thought, as I understood the testimony this morning, at least some of the opinion that was expressed was that the community health representatives really perform a different function than we're talking about in home health care or at least partly different in that they're more involved in the public health and more involved in training and in this kind of thing than they are in the types of activities that are generally involved with home health care? Do you agree with that?

Mr. **Buzzard**. Yes; I do.

Senator **Bingaman**. Is there then a fairly large gap in services for Indian people which might not otherwise exist for the rest of the population in the home health care area? Doctor, would you have——

Dr. TEMPEST. I would agree with what Mr. Buzzard said. At least some of the gaps, at least in the Navajo, is the logistics and this sort of thing. I think this is sort of a new concept, too. We're switching over from what classically was the field health, prevention, immunization to home health care. I know the Navajo Tribe has been getting used to this. I think the testimony this morning was really on one segment of the Navajo Reservation. I think for the bulk of the reservation we're probably talking about a program from the tribe. But it's a very real need and increasing need because the alternative you're really not—you would like to use it in a very limited way, so you don't have the problems in home nursing care. Keeping people with that kind of nursing care is really optimal.

Senator BINGAMAN. I appreciate very much the testimony today. I have more questions to ask each of the agencies represented and will submit followup questions in writing. Thank you.

Our next panel is the State panel. We have Regis Pecos, who is executive director of the New Mexico Office of Indian Affairs, accompanied by Mary Lou Martinez.

Catherine Salveson, program unit supervisor for the State Agency on Aging, and Gene Varela, also with the State Agency on Aging.

If they could come forward, please.

Also, let me welcome Manuel Tijerina, who is the secretary of the State Human Services Department. We appreciate him being here very much.

Regis, do you want to start?

STATEMENT OF REGIS PECOS, SANTA FE, NM, EXECUTIVE DIRECTOR, NEW MEXICO OFFICE OF INDIAN AFFAIRS, ACCOMPANIED BY MANUEL TIJERINA AND MARY LOU MARTINEZ

Mr. PECOS. Thank you, Senator. Before I begin let me just acknowledge and thank all the elderly people from the tribal communities for being here today.

Without belaboring the point, Senator, I think it's fairly evident from the testimony today that there are large gaps that exist in the communication and coordination of the programs designed to enhance the quality of health care and well-being of the elderly Indian people in the State of New Mexico.

Two years ago our office completed an appropriations study for the purpose of assessing, like we're doing here, the human and financial resources made available directly to tribes or Indian individuals by the State government. And the conclusion of that appropriations study was very clear. Much like we hear today, we found very low-participation levels of Indian seniors throughout this State in State programs. Another in-house document, that the health and environment department put together, concluded that while overall the health and environment department has been responsive to the needs of Indians, its funding and public outreach appear to be major areas that need improvement.

Those two studies, I think, point out the need for better coordinated efforts between the appropriate entities that provide various kinds of services to this population. You're talking about tribal governments, State government and the Federal Government. I think it's been put in many different ways. We totally lack, in many ways, any kind of coordinated effort. This leads to a situation where we're not truly maximizing the resources that are available.

When you consider the dual status of the citizenship of Indian people in this country, and the fact they're eligible to receive services directly through their tribal governments as well as the States they reside in, one would think that because this population is drawing from two sources it ought to have the best of health programs and services. But that's not the case, you know. In fact, it's contrary, due to the lack of coordinated efforts among the multiple entities involved in service delivery programs.

You have a situation where many of these peoples needs are not being adequately met. This whole thing is complicated with the ongoing debate of who is a primary service provider versus who is a secondary service provider. This ongoing debate at some point needs to be clarified, in terms of the trust relationship of the Federal Government to the Indian population. Given the financial situation of this State in particular, and the diminishing resources from the Federal Government, the State government is put in a very difficult position of having to assume providing services to a large group of people.with a very limited resource base.

Unless at some point this is clarified, you're going to continue to see situations develop where there is confusion and dispute, in terms of who has responsibility to provide certain kinds of services.

One of my recommendations is that there be some attempt made to clarify the issue of primary and secondary service providers, as well as some comprehensive statement of how these multiple entities ought to be working together in a coordinated fashion. I think we're very fortunate here in the State of New Mexico that we do have a gentleman like Secretary Tijerina in HED, and personnel in the Agency on Aging, who are very receptive to strengthening the Indian-State relationship and providing services as best they can with a limited amount of resources.

My concern is that when these kinds of people go, people who have been very active in working with tribal governments, things will change in such a way to create inconsistency, in terms of how the State deals with the Indian population in a variety of different situations. I think this is necessary that everyone has a clear understanding of their responsibilities in providing these kinds of services. That, in sum are our concerns.

Our studies reveal that about 9 percent of the New Mexico's population is native American, and yet you have participation levels, in a variety of cases, of Indian elderly, at less than 1 percent of a program's appropriations. These participation levels are about at the lowest level in almost every category.

The kinds of situations that develop are very complex, because of the jurisdictional issues. This can lead to a very inconsistent way of dealing with these situations. But there are people who have been very supportive in terms of strenghtening the relationship, as I've mentioned.

One example that would exemplify the kinds of cooperative efforts that can be developed is something that we're doing with the Human Services Department. This is a project at the other end of the age spectrum, involving children and a multiteam effort of social workers at the tribal level, and the county level, the State, Indian Health Service and the Bureau of Indian Affairs. With this kind of multiteam approach, I think everyone can come to some concensus in how far they carry their responsibilities and where others pick up. But this ought to be the rule rather than exception of how we provide services throughout all the agencies in the State. But Aging, I think, has its own testimony to present. HED, HSD, the facts and the figures are all well documented. The documents have been submitted for your review.

[The prepared statement of Mr. Pecos follows:]

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STATEMENT BY
REGIS PECOS, EXECUTIVE DIRECTOR
OFFICE OF INDIAN AFFAIRS
Before the
SENATE SPECIAL COMMITTEE ON AGING
FIELD HEARING
September 3, 1986

As the entity of state government charged with overseeing and helping to coordinate state services and programs for New Mexico's 22 tribal groups, we, of course, take a great interest in the outcome of this field hearing and are pleased to have been asked to provide an overview of the state's services for the Indian elderly of New Mexico. We salute the interest you have taken in this subject, and thank Senator Jeff Bingaman and his staff for organizing this effort.

There are three state offices, in particular, which interact and affect the quality of life for New Mexico's Indian elderly -- the Health and Environment Department, the Human Services Department, and the Agency on Aging. The Agency on Aging will be presenting its own report; so our comments will be restricted to a review of the other two departments.

As an overall observation, which is most likely applicable to all other states where there are significant numbers of Indian residents, it seems there are tremendous gaps in communication between the various parties responsible for providing services and health care for Indian elderly -- especially between the state government and the federal government, and between the state government and the tribal governments.

There is little coordination of programs between the Indian Health Service and other federal agencies providing services to Indian elderly -- such as the Health and Human Services Department, the U.S. Department of Agriculture, and the Housing and Urban Development Department -- and their counterparts in state government. On top of this, most tribal governments and Indian individuals know little or nothing about health services and programs operated by the state which they could qualify for and utilize to address their pressing health problems.

Therefore, improving communication and knowledge of one another's potentials and programs, which can or do serve the Indian elderly, must become a major priority among those responsible for Indian health. Along these lines, we are happy to report we are working with the state's Health and Environment Department to host a two-day conference in November which will draw together the various parties involved in this complex web of health problems and solutions to review where we stand and where we go from here.

As to more specific programs and problems associated with state services to Indian elderly, a brief review of the services of the Health and Environment Department and the Human Services Department follows.

Two years ago, our office conducted a study of appropriations devoted by state agencies to New Mexico's Indian people. In reviewing HED's responses to our study, we found that Indians are receiving far less a percentage of service dollars than the percentage they comprise of the state's population as a whole, except in the area of substance abuse. For instance, in mental health services, the department allocated less than one percent of its funds for Indian outpatient services on reservations, and about five percent of its developmental disabilities funds. This is in spite of the fact that Indians represent about nine percent of the state's population.

The department's Health Service Division, which operates a number of programs Indian elders could be served under, allocated three percent of its funds to Indian service contracts, according to the results of the study, while Emergency Medical Services provided seven percent of its funds to tribal EMS programs.

In a study conducted internally by HED on its Indian contracts and health services in 1985, its summary stated, "Overall, the Health and Environment Department has been responsive to the needs of Indians, but funding and public outreach appear to be major areas needing improvement." The study goes on to more specifically identify problems and potential solutions. A sample of these follows.

- There is a need to develop better coordination between IHS and Behavorial Health Services to develop uniform client data systems.
- There is a need to encourage non-Indian programs serving a certain percentage of Indians to have Indians on their boards of directors and to hire more Indians in their programs.
- Program managers need to visit community-based programs more frequently.
- There is a need for the state to provide more technical assistance to tribal health programs.
- There is a definite need for more Indian contracts with HED's Developmental Disabilities Bureau.
- There is a need to have some Indian representation on the board of directors of the Developmental Disabilities community-based programs.
- The Mental Health Bureau needs to become informed about Indian Health Services and delivery systems, and direct joint planning with IHS.
- There is a need for expanding primary care services to Indian tribes statewide.
- There is a need for more ambulance services among Indian communities in New Mexico and operational monies, staff and equipment.
- None of the clinicians under contract to provide adult health and nutritional bureau services in the state are Indian.
- Relatively few Indians seek the services of the Field Health Offices, even though they are qualified to receive them.

- Records for FY '73 show that 84,964 patients visited Field Health Offices. Of that number, 1,234 were Indian.
- Currently there are no contracts between the Health Services Division's Dental Program and tribal governments.
- There are no direct contracts between the rehabilitation centers of the Office of Rehabilitation Services and the tribal governments, Indian health authorities, U.S. public health programs, etc.

Both the results of our office's study and HED's internal study clearly point out the gaps in services and communications in serving New Mexico's Indian populace as a whole, and its elderly populace.

The Human Services Department also oversees a number of programs and projects which Indian elders participate in. But, as with HED's programs, the level of Indian participation ranges from adequate to extremely low. It seems as if Indian individuals and tribal governments are not aware of these programs, which would indicate the department needs to make greater efforts to publicize its program and to actually get out onto the reservations to review their services with tribal administrators and the Indian elderly populace.

For instance, only one percent of those served through HSD's Adult Protective Services are Indian, and less than one-tenth of one percent of those served by the department's adult handicap day care are Indian. However, other social service programs run by the department show higher Indian participation, such as Critical In Home Care (11 percent are Indian) and Home Care (20 percent are Indian).

In addition to the social service programs overseen by HSD, the department is responsible for income support programs in the state. In the appropriation study conducted by our office two years ago, the department stated that it provided funds to Indian individuals along the following lines (there was no specific breakdown for elderly): Residential Care--0.4 percent; Low Income Home Energy Assistance Program--10 percent; Medicaid--8 percent; Food Stamps--15 percent. The department also provides funding for emergency food and shelter needs, but the level of Indian participation could not be documented.

Before concluding this report, we would like to present some statistics on New Mexico's Indian elderly populace which serves to place their needs in perspective. According to the 1980 U.S. Census, there were 3,216 Indian elderly living on New Mexico reservations at the time of the census. The median income for these elderly was $6,638. This dismal income level resulted in 2,591 being designated as living below the poverty level. In the state as a whole, there were 7,365 Indian elders identified in the 1980 U.S. Census. Of those 60 to 65 years of age, 43 percent existed below the poverty level. Of those 65 to 74 years of age, 49 percent lived in poverty; and of those 75 years or older, 48 percent lived in poverty.

From these figures, it can clearly be seen that New Mexico's Indian elderly are in dire financial conditions. If called upon to take care of their health needs on their own, they would perish. For them, the health net provided by the federal and state governments is absolutely essential.

This, then, raises the inevitable question -- who is responsible for providing this care? The state says the federal government is; but Washington says the state must begin to assume some primary care responsibilities. And, as citizens of the state, as well as the nation, Indian elders do legally qualify for services from both entities. One would think this would result in the best possible health care anyone could obtain at any cost. Instead, it has sparked a debate over primary and secondary health service responsibilities. The result is a people with obvious need being provided the worst health care of any ethnic or social group in the country. Clearly, this question of jurisdiction and responsibility is a major stumbling block for this committee and the various parties involved in Indian health services to address.

To say the state is doing nothing for its Indian elderly is surely false; but to say it's doing enough is equally amiss. Progress is being made. Twenty years ago the state did little or nothing for Indian elderly. Every year it slowly increases its involvement and services to the Indian elderly; but as our overview shows, its Indian-oriented health services are still very limited. Now, with the federal government attempting to scale back its commitment, it is clear the state cannot abandon its newly-found sense of responsibility to its Indian citizens. If anything, this commitment must be broadened and strengthened.

We thank you for your attention, and the opportunity to make this presentation today. It, along with some supporting documents from the departments of Health and Environment and Human Services, will be turned over to your staff to become part of the permanent record of this hearing. Again, thank you; and best of success in your endeavor to address the critical condition of this nation's Indian elderly.

The following are adult services the Human Services Department funds:

ADULT PROTECTIVE SERVICE (APS):

The goal is to ensure the safety of adults who require protection from abuse, neglect and exploitation; and to achieve this in the least restrictive environment. Services include: the investigation of complaint; intervention or referral to other community resources; assisting clients to accept needed services; working with families or other individuals to alleviate the precipitating factor; and working with the judicial system to remove victims to a safer place or to prosecute the perpetrator. This statewide program is legally mandated and provided directly only

7,200 referrals per year
1% only Indian elderly

less a reflection of how native Americans treat elderly than lack of knowledge that service exists; confusion by HSD as to who has jurisdiction.

DAY CARE FOR HANDICAPPED ADULTS:

Its purpose is to help maintain the family unit, enhance family mental health and prevent inappropriate and premature institution of the handicapped adult while allowing him/her to remain in the community. This service provides an organized, structured program of therapeutic services and activities designed for adults whose handicaps their ability to pursue their activities of daily living.

There are only four Department contracted programs - two in Albuquerque; one in Santa Fe and one in Las Cruces. They serve 129 clients per year with native American elderly making up less than 1/10 of 1% of clients. Problem is one of access.

CRITICAL IN HOME CARE:

A statewide program providing a cost effective alternative to nursing home placement. A caregiver or family member is paid a maximum of $400 per month to provide 24 hour care to disabled, handicapped or frail elderly. 334 clients per month are currently receiving CIHC of which 11% are Indian elderly. Problem is that the program hasn't received an increase in funds from the Legislature in three years. There is a two year waiting list of 181 clients.

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HOME CARE:

A statewide program providing personal care such as bathing, housekeeping and shopping and environmental services such as chopping wood, feeding livestock, etc. for clients. This service is provided both directly through HSD and through Title XX contract. 1,182 clients receive this service statewide. The Navajos receive 50% of the contracted dollars. 20% of the total clients served are the Indian elderly.

DOMESTIC VIOLENCE:

Shelters and their ancillary services are available statewide through Title XX contract. Although 7% of the 1,646 clients served are native American, none are elderly.

COORDINATED COMMUNITY IN HOME CARE:

The CCIC program implemented in 1982, is the Medicaid waiver pilot project designed to provide an alternative to institutionalization. Seventy five percent of the program is funded by the federal government. Clients must meet the criteria established for intermediate care (nursing home) placement. Two of the seven pilot areas serve native Americans only. Seventy seven Indian elderly are being served under this waiver.

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UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

JEFF BINGAMAN
UNITED STATES SENATOR

FIELD HEARING ENTITLED

CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS

September 3, 1986

Santa Fe, New Mexico

STATEMENT BY Mary Lou Martinez, Director
Health Services Division
FOR

Jerry Manzagol
Secretary
New Mexico Health and Environment Department

Mr. Chairman, thank you for giving me the opportunity to testify before the Special Committee on Aging during its field hearing concerning the Continuum of Health Care for Indian Elders. We sincerely hope that the department's perspective, delivered today, will assist the Committee in understanding the "extent of state services and how improved coordination may take place between all those concerned with improved health for Indian seniors."

I think it is most appropriate to remark that the 1986-90 State Health Plan identifies the goal that addresses the need for establishing areas of responsibility for Native American health care problems. Included within this goal is the direction to:

Identify service gaps and identify appropriate strategies for eliminating those gaps.

Provide for a coordinated system for the delivery of health care services to Native Americans, especially to address the problems of alcoholism, lack of prenatal care, and accidents.

This goal addresses the following Statewide Health Priorities:

Coordination/Service Delivery
Distribution of Health Care
Access to Health Care
Minority Health

Mr. Chairman, the purpose of this hearing today, as you stated in your recent letter to Governor Toney Anaya, "is to assess the access, availability, and quality of health care and supportive services to American Indian elders." I think you will agree that this State Health Planning goal, and the priorities that it addresses, with the exception of prenatal care, will be greatly assisted in their accomplishment by the testimony received during this hearing. We will listen well to what is being said here today.

The New Mexico Health and Environment Department is the largest agency in state government with approximately 3500 employees and a current annual operating budget of $ 155 million dollars of which 88 million or 57% are federal funds and 67 million or 43% are state funds.

The department's operational interest is in service. This fact is evidenced by its 2900 employees, representing 83% of the total departmental work force, who are assigned to field locations statewide to deliver health and environmental services to New Mexico s 1.4 million residents in every county and municipality.

The major areas, within which health services are offered to all races and ethnic groups and to women and men of all ages, are very extensive. Hundreds of thousands of New Mexico residents receive preventive, curative and restorative services annually for infectious and chronic diseases, behavioral problems and biological and physical impairments.

The areas addressing the needs of the elderly, including the Indian elderly, are, by division and by program, the following:

Division	Program
Health Services Division	1. Cardiovascular Health
	2. Diabetes Control
	3. Cancer Control
	4. Tuberculosis Control
	5. Sexually Transmitted Disease Control
	6. Nutrition Education
	7. Immunization
	8. Primary Care Coordination
	9. Emergency Medical Services Coordination
	10. Smoking Prevention and Cessation
	11. Unintended Injury Control (Automobile accidents, falls-especially the elderly)
	12. Rehabilitation Services
	13. Nursing home licensing
	14. Adult Residental Home licensing
	15. Hospital licensing
Behavioral Health Services	1. Contracted Community Alcoholism Treatment
	2. Contracted Community Mental Health
	3. Contracted Drug Abuse, Community Drug Treatment, and Substance Abuse Prevention Services
	4. Contracted Community Developmental Disabilities

Office of Institutional Coordination	1. Residential Institutions Geriatric, Skilled and Intermediate Nursing Care, Behavioral, and Developmental disabilities, medically fragile and severe retardation.

The Scientific Laboratory Division and the Administrative Services Division provide support services to the other divisions.

The number of Indian elderly that are seen by the various programs operated, contracted, or coordinated by the department are very limited, for example, during the fiscal year beginning July 1, 1984 to June 30, 1985, the Health Services Division served 47 Indian men and women over age 61. This amounted to 0.5% of the total elderly of 9,376 served during the same time period.

Currently, the Las Vegas Medical Center has 4 Indian elderly patients and Ft. Bayard Medical Center (Geriatric) has 1 Indian elderly patient. The Rehabilitation Centers and Ft. Stanton Hospital do not have any Indian elderly patients.

No patient or client data is immediately available for the other departmental programs since the tabulation system is manually run or the programs do not collect data on ethnicity or race.

There are several reasons why there is such low participation in departmental programs.

1. The Health Services Division's primary mission is health promotion and disease prevention. With the exception of unintended injuries, most of the health problems of the elderly (including the Indian elderly) are chronic in nature such as cancer, heart disease, etc. which are best treated in acute care clinics and hospitals. Health Services does not operate those types of health care facilities.

2. The division's cancer control program emphasizes public and professional education regarding primary prevention, direct client screening for early detection, referral and follow-up and patient advocacy.

Where there is an opportunity to stay within the mission of the division and serve the elderly, no effort is spared to address the problems of the elderly.. For example, one of the objectives of the Injury Control program this year is to identify the etiology of falls and burns, among senior citizens over 65, and implement interventions to decrease the incidence of those types of unintended injuries. Indian seniors will be included in this project.

3. Certainly, the great distances in New Mexico coupled with the hardships associated with the separation from families or homes, account for the low number of patients in the department's hospitals. On the other hand, the hospitals, in many cases, do not have the employees with the Indian language skills or cultural understanding to effectively work with the Indian senior. The problem of not being able to communicate does not provide an inviting and reassuring atmosphere for Indian patients admitted to those hospitals.

4. The federal system of health care also attends to the care of the Indian senior and in predominantly Indian areas, the Indian Health Service clinics and hospitals receive the greatest Indian patient loads. The other local clinics, that are also available in these communities, often do not receive very many patient visits, from Indian elders, for this reason.

The list could go on and on. The need to provide health care to the Indian elderly is important. The need to identify who offers health care and at what level to the Indian elderly is an important first step in the process of identifying the gaps in service.

The Health and Environment Department and its divisions with their multiple programs are available to serve the Indian elderly within the scope of their individual missions. Any way that we can be of additional assistance to you and your committee, in identifying and resolving these problems, will be our pleasure.

Details of the programs and services identified in this testimony can be obtained by contacting the:

Office of the Secretary
New Mexico Health and Environment Department
P.O. Box 968
Santa Fe, New Mexico 87504-0968.

Thank you.

Senator **Bingaman**. Thank you very much. Manuel, we appreciate you being here.

STATEMENT OF MANUEL TIJERINA

Mr. **Tijerina**. Thank you, Senator. In the interest of time Regis and I had agreed he would be the spokesman at least for our Department. His agency is administratively attached to the Human Services Department.

But I would like to emphasize several points that Regis made, Senator. One is that the provisions of services to the Indian population cannot depend on the personalities involved. There are a great many issues that need to be clarified at the Federal level. And he pointed out several of them, but one of the concerns that this Administration has always had uppermost is the respect for the sovereignty of the Indian nations.

So what we have—the services we can provide, the access to the tribal land, I think we need to work out amongst ourselves. And in certain instances the New Mexico Human Services has, in fact, worked them out. We have several direct powers agreements. Again, at the other end of the spectrum with respect to the Indian child welfare.

Another point that I would like to make, Senator, is that as a State administrator we're very concerned about both the perception and what appears to be the practice of the Federal Government thrusting its obligation as a trustee of Indians on to the States. We have in several instances—and Regis mentioned this—the ping-pong effect we put the client into. They come into the State for help. State tells them they have to apply to the feds. The feds say they have to apply to the State, and that obviously is not a tenable situation.

We have with respect to the general assistance program, for example, ongoing dispute, which I think has finally been resolved to the satisfaction of both parties. But the BIA had initially indicated to us that they were going to recommend termination of the program, the Federal GA Program in the State, because the State had a program. The State has a very, very minor program. I think the Federal GA Program in New Mexico is about $12 million. The State program is in the vicinity of $700,000, clearly not comparable programs.

But our concern again was not whether or not there was the program, but the perception the Federal Government thrusts its trust responsibilities to the States. We would again point out to you that what the State does on behalf of its citizens should be total and apart and perhaps a supplement to the responsibility of the Federal Government.

That concludes my remarks, Senator. I and several members of my staff are available to answer any questions you might have about the program.

Mr. **Pecos**. Senator.

Senator **Bingaman**. Yes.

Mr. **Pecos**. Where local people have been given the responsibility and opportunity to provide services by way of subcontracts or direct contracts seems to have created the best of situations, in terms of the quality of services being provided. Such an approach, we recommend, ought to be pursued, to make as many of these contracts available directly to local entities as possible.

Senator **Bingaman**. Catherine Salveson, who is with the State Agency on Aging. I'm glad to have you here.

STATEMENT OF CATHERINE SALVESON, SANTA FE, NM, PROGRAM UNIT SUPERVISOR, NEW MEXICO STATE AGENCY ON AGING

Ms. **Salveson**. Thank you. Senator Bingaman, distinguished guests, ladies and gentlemen. I'm here to speak on behalf of Rita B. Maes, director of the State Agency on Aging. We appreciate this opportunity to share what the State Agency on Aging is doing for, and with, the native American tribes and pueblos in New Mexico.

Our statutory and legislative mandate is to work on behalf of all senior citizens in New Mexico, including native Americans. Our agency mission for health care includes promoting access to available health care, working with health care agencies and providers to increase the availability of health care for senior citizens and promoting the development of quality health care services. In the last few years, we have focused on the area of health promotion, encouraging older New Mexicans to make positive personal decisions about their own health care. To this end, we have shared much information and sponsored activities that promote better health and wellness.

Let me note that we are not an agency that provides primary health care as is done by clinics or public health offices. We focus on the supportive services that get people to care, or that assist the elderly in making choices about their personal health. When I speak of services, they revolve around the community services provided through senior centers. We believe that the centers are a key element in the provision of care for the elderly. Through the assistance of county health offices, rural clinics, other health care providers and many retired health professionals, senior centers have provided such health promotion services as blood pressure checks, health fairs, and annual flu shots.

In addressing the continuum of health care for Indian elders, I would like to speak to three areas. First, the fiscal resources provided through us to Indian programs from State general fund and severance tax dollars. Second, I will discuss some of the program resources that we provide to Indian programs, and finally, our coordination and working relationship with the pueblos and tribes of New Mexico.

Looking at the fiscal resources, in the past 5 years—ending June 30 of this year—$1,643,033 in State funds has been provided the tribes and pueblos in New Mexico for senior services. I have with me a breakdown by years, tribe, and amount, which we submit for the record. This averages to $343,934 per year. The funds break out into three basic categories. First, using 1985-86 as an example, $260,556 was provided for capital outlay projects. This includes the purchase of vehicles, renovation of senior centers, and new construction of buildings. Second, for providing senior services, $84,028 was allocated and used primarily for transportation, nutrition, and outreach activities. Finally, funds were provided in the amount of $74,012 for employing older persons and to provide volunteer opportunities through the Senior Companion and Foster Grandparent Programs. Allocations for the current fiscal year are comparable.

Let's look at program resources. In addition to ongoing programs, native American elders have been included in programs funded specifically for health promotion. For example, we had a contract with New Mexico State University's Gerontology Center, TIGRE. They conducted activities which included a medication awareness initiative, exercise program in senior centers, a conference on health promotion, and specific health promotion awareness efforts. Indian programs were made aware of the activities and they participated in all of them. Training on health promotion was made available to Title VI Program directors during their regularly scheduled meetings. In addition, a small grant was provided to Laguna Pueblo—on behalf of all pueblos—for the development of two culturally sensitive health promotion posters.

I wish to note that the sharing of program resources is not limited to those tribes and pueblos with whom we have contracts. We have attempted to include all tribes and pueblos in our activities and programs.

Let's look at coordination. Every effort is made to include the pueblos and tribes in our health education initiatives. In an ongoing way, tribal seniors and program staff are invited, provided some travel support, and given the opportunity to participate in regular State agency on aging quarterly training and our annual conference on aging. This training is funded primarily by title IV of the Older Americans Act and State funds.

The 1986 conference, which was held last week, included many native American seniors, some of which are here today. The Title VI Programs were provided 10 scholarships to assist Indian elders in attending at no cost. Indian programs were well represented on the planning committee and provided major input into a workshop on mental health issues.

This past year specific training has been provided to Indian Health Service nursing staff in Albuquerque and Santa Fe. The State agency legal services developer and program supervisor provided training on cultural sensitivity and issues of death and dying. Title VI Program directors and the Navajo Area Agency on Aging are included in all mailings which go out to the New Mexico aging network. They also receive copies of all printed educational materials which the agency distributes.

Our office has a close working relationship with the Health Promotion Bureau of the Health and Environment Department and the Adult Protective Services Bureau of the Human Services Department. As materials are generated through joint activities with these agencies, they are distributed to the Indian programs.

Looking at the specific Indian program issues, several issues have been of concern to the Indian service providers as well as the Indian elderly. Of these, two have surfaced which affect our office. First, the Title VI Coalition of the New Mexico Indian Council on Aging have requested that we establish an Indian desk that would respond to the special needs of the Indian elderly. Because of budgetary limitations we have been unable to fund such a position. In order to meet the need we have turned to the New Mexico Office of Indian Affairs, who we believe has the expertise we require. We have developed a working relationship with that office which has allowed us to consider them to be an ex officio Indian desk. They have actively assisted us in identifying problems or concerns, provided us with information and data for use in making decisions, and helped us negotiate several contracts. We very much support the maintenance of this office. Our budget request to the 1987 legislature does not contain any expansion items. We are committed, during these times of severe fiscal cutbacks, to putting as many dollars as possible into the provision of direct services to seniors, and to consolidate and make administration as efficient as possible. Our priority is to maintain funding for programs at the same level that we had last year.

The second concern is about the allocation of title III funds to Indian programs. Currently no title III funds are contracted to any tribes or pueblos. At the time that title VI was funded we were not allowed to provide both title III and title VI dollars to the same program. Subsequently the Administration on Aging issued rules which did allow joint funding provided that separate population groups were being served by the different funds. But by that time we had committed title III dollars to other programs in the State through a proportional share formula. Unfortunately any efforts to shift title III funds to the Indian programs would require decreased funding to current title III programs. For your information, the Administration on Aging currently subtracts a proportionate share of the New Mexico title III allocation and assigns it to Arizona for the Navajo Nation. In a time of both Federal and State cutbacks we see no solution to this situation. A shifting of allocations would mean additional cuts to programs who have recently reduced the number of meals that they are providing and have in some cases closed down meal sites on certain days of the week to stay within the budget.

Concerning our problem areas, perhaps the greatest problems in dealing with the Indian tribes and pueblos has been in establishing the mechanisms for contracting. Systems are much more complex when the State of New Mexico and a sovereign nation are working together.

As the State agency on aging which serves all New Mexico senior citizens, we want to thank the employees and program staff who serve Indian elders. What we have experienced in dealing with them is a dedication to their culture and their people. The success of their programs and the spirit and enthusiasm of the Indian senior center participants reflects the work that the staff is doing. They deserve recognition for their work. The State agency on aging staff will continue to be available to them for any assistance we can provide.

In conclusion, we wish to thank the Senator for this opportunity to share our involvement in the continuum of health care for Indian elders. We also thank him for his ongoing concern for all senior citizens in New Mexico.

[The prepared statement of Ms. Salveson follows:]

State Agency on Aging STATE FUNDING TO INDIAN TRIBES

YEAR	INDIAN TRIBE/PUEBLO	PURPOSE	AMOUNT	FUND SOURCE
80-81	Eight Northern IPC	Senior Services	7,044	General Fund
80-81	Navajo Nation	Senior Services	58,018	General Fund
		80-81 TOTAL	65,062	
81-82	Eight Northern IPC	Senior Services	12,363	General Fund
81-82	Mescalero Apache	Senior Services	2,000	General Fund
81-82	Nambe Pueblo	Capital Outlay	2,200	General Fund
81-82	Navajo Nation	Capital Outlay	27,500	General Fund
81-82	Navajo Nation	Senior Services	60,738	General Fund
81-82	Picuris Pueblo	Capital Outlay	2,200	General Fund
81-82	Pojoaque Pueblo	Capital Outlay	2,200	General Fund
81-82	San Ildefonso Pueblo	Capital Outlay	13,200	General Fund
81-82	San Juan Pueblo	Capital Outlay	2,200	General Fund
81-82	Santa Clara Pueblo	Capital Outlay	2,200	General Fund
81-82	Taos Pueblo	Capital Outlay	2,200	General Fund
81-82	Tesuque Pueblo	Capital Outlay	2,200	General Fund
		81-82 TOTAL	131,201	
82-83	Eight Northern IPC	Senior Services	12,346	General Fund
82-83	Mescalero Apache	Capital Outlay	10,000	General Fund
82-83	Nambe Pueblo	Capital Outlay	13,000	General Fund
82-83	Navajo Nation	Senior Services	54,549	General Fund
82-83	Navajo Nation	Capital Outlay	42,650	General Fund
82-83	Picuris Pueblo	Capital Outlay	13,000	General Fund
82-83	Pojoaque Pueblo	Capital Outlay	13,000	General Fund
82-83	Tesuque Pueblo	Capital Outlay	13,000	General Fund
		82-83 TOTAL	171,545	
83-84	Eight Northern IPC	Senior Companion	3,000	General Fund
83-84	Eight Northern IPC	Senior Services	21,005	General Fund
83-84	Five Sandoval Pueblo	Senior Services	3,034	General Fund
83-84	Navajo Nation	Senior Services	64,304	General Fund
		83-84 TOTAL	91,343	
84-85	A.I.P.C.	Senior Companion	61,890	General Fund
84-85	Acoma Pueblo	Capital Outlay	17,628	Severance Tax
84-85	Cochiti Pueblo	Capital Outlay	2,683	Severance Tax
84-85	Eight Northern IPC	Senior Services	22,790	General Fund
84-85	Five Sandoval Pueblo	Senior Services	3,034	General Fund
84-85	Isleta Pueblo	Capital Outlay	16,801	Severance Tax
84-85	Jemez Pueblo	Capital Outlay	2,984	Severance Tax
84-85	Laguna Pueblo	Capital Outlay	2,738	Severance Tax
84-85	Nambe Pueblo	Capital Outlay	2,000	Severance Tax
84-85	Navajo Nation	Senior Services	58,204	General Fund
84-85	Navajo Nation	Capital Outlay	362,840	Severance Tax
84-85	Picuris Pueblo	Capital Outlay	2,000	Severance Tax
84-85	Pojoaque Pueblo	Capital Outlay	2,068	Severance Tax
84-85	San Ildefonso Pueblo	Capital Outlay	2,000	Severance Tax

State Agency on Aging STATE FUNDING TO INDIAN TRIBES

YEAR	INDIAN TRIBE/PUEBLO	PURPOSE	AMOUNT	FUND SOURCE
84-85	San Juan Pueblo	Capital Outlay	2,000	Severance Tax
84-85	Sana Ana Pueblo	Capital Outlay	2,758	Severance Tax
84-85	Sandia Pueblo	Capital Outlay	2,758	Severance Tax
84-85	Santa Clara Pueblo	Capital Outlay	17,433	Severance Tax
84-85	Santo Domingo Pueblo	Capital Outlay	17,638	Severance Tax
84-85	Taos Pueblo	Capital Outlay	1,241	Severance Tax
84-85	Tesuque Pueblo	Capital Outlay	2,000	Severance Tax
84-85	Zia Pueblo	Capital Outlay	2,480	Severance Tax
84-85	Zuni Pueblo	Capital Outlay	50,000	Severance Tax
		84-85 TOTAL	657,968	
85-86	A.I.P.C.	Senior Companion	25,050	General Fund
85-86	Eight Northern IPC	Capitol Outlay	4,528	Severance Tax
85-86	Eight Northern IPC	Senior Services	22,790	General Fund
85-86	Five Sandoval Pueblo	Senior Services	3,034	General Fund
85-86	Jicarilla Tribe	Capital Outlay	3,397	Severance Tax
85-86	Laguna	Capital Outlay	2,500	Severance Tax
85-86	Navajo Nation	Capital Outlay	142,044	Severance Tax
85-86	Navajo Nation	Senior Services	58,204	General Fund
85-86	Other Pueblos/Tribes	Capital Outlay	87,615	Severance Tax
85-86	Santo Domingo Pueblo	Capital Outlay	2,528	Severance Tax
85-86	Zuni Pueblo	Capital Outlay	17,944	Severance Tax
85-86	Zuni Pueblo	Foster Grandparents	3,000	General Fund
		85-86 TOTAL	372,634	
		GRAND TOTAL	1,489,753	

Senator **Bingaman**. Thank you very much. Let me just ask before we proceed, Mary Lou Martinez, did you have some additional comments you would like to make? We're glad to hear them if you do.

STATEMENT OF MARY LOU MARTINEZ

Ms. **Martinez**. Thank you, Senator. I do feel it is a great pleasure to be here this afternoon. We had an agreement with Mr. Regis Pecos that he would be the spokesman for the Health and Environment Department as well as for Human Services. I would only be reiterating some of his statements.

The concern that the Health and Environment Department has is in the area of the number of services being available for senior Indian citizens is very limited. And this is as a result of lack of funding, lack of resources, plus the fact that there are certain areas, particularly in the preventive health area, where services may be available but the population does not avail themselves of those services. Thank you, Senator.

Senator **Bingaman**. Thank you very much. Mr. Varela, who is here also, we are glad to hear from you if you have some comments you would like to make.

Mr. **Varela**. Senator, I appreciate the opportunity. I'm here primarily to answer any questions that come up.

Senator **Bingaman**. I really don't have any specific questions of this panel here. I appreciate all of your testimony. I think that the problem of agency coordination not only at the local level, but at the State and Federal and tribal levels is a major problem. I guess one of the things I hope can come out of this hearing is some kind of proposal or recommendation for how we can increase communication between Federal, State, tribal, and local officials, and see to it that all the resources that are available are in fact getting to the people that need it. So we will be back in touch with you. Thank you very much for the excellent testimony.

Mr. **Pecos**. Before we leave let me just take this opportunity on behalf of all Indian people in the State of New Mexico to publicly thank you and your excellent staff in their efforts in articulating the many concerns and issues that from time to time we bring to your Washington office, as well as your Santa Fe office. Your staff has been responsive, receptive, and always very willing to work with our office and the tribes in the State of New Mexico.

Senator **Bingaman**. Thank you very much. I appreciate it.

Our final two witnesses—and we may actually get this hearing over with close to when we scheduled it, which was 3 p.m.—are Larry Curley, who is a consultant on aging issues, now in Albuquerque; and Paul Nathanson, who is the director of the Institute of Public Law, at the University of New Mexico School of Law. We appreciate them both being here.

This last panel is called "Taking Charge." I guess that's an indication that you will tell us how to solve these problems that have been described by others. So we appreciate any wisdom that you can shed on that. Why don't we start with Larry and get your views, and then we will go to Paul after that.

STATEMENT OF LARRY CURLEY, ALBUQUERQUE, NM, CONSULTANT ON INDIAN HEALTH CARE

Mr. CURLEY. Senator Bingaman, and distinguished guests and all of you distinguished older people. It is a pleasure to be here and share with you my concerns, and I hope the concerns of all the Indian people here in New Mexico. Not only in New Mexico but the country as a whole.

You do have my written statement. I submit it for the record. I only ask one correction, and there is, I believe, on page 7 of my testimony it reads IHS' position on providing health checkup at a senior center. I think the words "is not" should be inserted between "senior center and country." Because without the "not" inserted it gives the wrong impression.

Senator BINGAMAN. OK.

Mr. CURLEY. Taking charge, I had a great number of hours to think about this. And it doesn't involve a credit card charging, which it implies. I think it concerns the problems that are related to older Indian people and the problems encountered at this particular point is not so much the lack of funding, not so much those kinds of issues. But I think at the bottom of the issue is we're dealing with a flux in the culture of the people. That there is a change that our elderly people are encountering. The kinds of environment they're now having to face is an alien environment. As a result there are standards that are used to define what are—who are the people who are well, or the people who are frail. Who are the people who are at risk. I think those definitions in itself present problems that we're having to deal with today. In terms of where do we go. What do we do with these policies. What do we do with many of the programs that are practically nonexistent.

In my testimony I ask the question, rhetorical question, does a continuum health care system exist in the Indian communities? No, it doesn't. It does not exist, because No. 1, continuum implies that there is an array of services that are available to older Indians, that are based upon their comparity levels. Services that are coordinated; that are interrelated and responsive to the needs of elderly people. This system does not exist.

You heard previous panels up here talking about why this is not the case. You asked a previous panel if there is a need for a broader national guideline and impetus that needs to occur. My answer to that is emphatically, yes. I believe the Congress of the United States has a moral responsibility to set the tone for how services are delivered. I think this country is based upon an idea of justice and equality. I believe that the service delivery system that exists for elderly people do not reflect those ideas. I believe that in order to do so a basic restructuring in terms of the philosophical direction of a lot of the Federal agencies that provide these services to our elderly people needs to be reoriented.

That basically is I believe that the development and implementation of a national Indian aging policy that embraces the underlying concept of tribal sovereignty. The preservation of the tribal culture. I think basically this problem of culture that I refer to is essentially that. Is that at this particular point in time when the Government is espousing the idea of self-determination as a governmental

Indian policy as a way also of preserving the culture. It is the preservation of the culture by their rules, non-Indian rules, which says in order for you to promote the self—the mode of self-determination you have to comply with the provisions that promote economic self-sufficiency. You have to have programs that promote independence.

I think the characteristic of Indian people and Indian community has been it is not an independent. It is not an individualistic notion that Indian people have. It is more communal. It is a tribal, and it is an interrelated community. It is a culture that stresses those factors. As to how the policy stresses the very compoents that destroy the essence of any community, I believe, is very detrimental. The policy that I refer to needs to be developed at a national, congressional level, and at the local and statewide level.

I believe, again, that another coordinating group needs to be established at its local level, at the tribal level. One of the recommendations that I have made, Senator, is that tribal governments, I believe, need to be put in a position of creating areawide planning agencies that have total responsibility and the authority to coordinate and implement services at the tribal level. I find too often at the local level that program directors, which I also noted are an expendable commodity at a tribal level, have the problems of dealing with turfism. Problems of getting another individual or another program's responsibilities. I believe by mandating at a congressional level I hope through the amendments to the Older Americans Act that we can create that kind of local coordinating body. There are 664 bodies in the non-Indian community. That is referred to as the aging network. If you look at any schematic organizational chart of the Administration on Aging refers to the aging network. The title VI programs are left out of that network.

There is an issue of comparability. At some point the Administration on Aging I believe will push the concept of coordinated service into the system in order for Indian tribes to be there ahead of the game. I believe that those kinds of issues need to be looked at and possibly mandated. Training, since directors seem to be an expendable commodity as I referred to earlier. A lot of title IV program directors at the tribal level are young. They're inexperienced. They do not have the training to develop comprehensive coordinated systems. I believe this needs to be coupled with increased training in the title VI program, and hopefully that this will go along with resolving that particular problem.

I believe that other agencies such as the Indian Health Service, Bureau of Indian Affairs, Department of Housing and Urban Development, Department of Transportation, all Federal agencies have a responsibility. That responsibility obviously is not something that should be burdened upon the Federal Government, but it is also a responsibility that needs to be shared by the State government as well as tribal governments at the local level. I think we have equal responsibility. I think it is often too easy to point fingers and say it is somebody else's responsibility.

Thank you, Senator.

[The prepared statement of Mr. Curley follows:]

STATEMENT PREPARED

by

Larry Curley

The Continuum of Health Care for Indian Elders
by the U.S. SENATE SPECIAL COMMITTEE ON AGING
Chaired by SENATOR JEFF BINGAMAN
Santa Fe, New Mexico
September 3, 1986

Good afternoon, Senator Bingaman and members of the Senate Special Committee on Aging. It is a pleasure to address this field hearing regarding the Continuum of Health Care for Indian elders. My name is Larry Curley, I am a Navajo and I am currently a Ph.D. student at the University of New Mexico in Political Science with an emphasis in Public Policy. Prior to my return to school, I have served in the following capacities, with the most recent first and like manner to my first position: As the Executive Director of the Laguna Rainbow Corporation, a non-profit organization on an Indian reservation providing community-based services and institutional care to Indian elderly; As Director of the Office of Training and Technical Assistance for the National Indian Council on Aging which enabled me to work with the nation's Indian aging programs; As the Legislative Liaison for the National Indian Council on Aging during which I worked out of Washington, D.C. and monitored the legislative course of the Older Americans Act, Title VI program; and finally, as the planner for a county-wide Area Agency on Aging in Tucson, Arizona.

In each of these positions, I have had the opportunity to observe the planning, development, and implementation of services to the groups that are targetted as "socially and economically disadvantaged", "at risk", or "truly needy". Most of these efforts have had mixed results. But in most instances, however, the planning, development, and provision of services to those elderly most needing services have fallen through the service net through faulty premises about those who need the services.

A concern for the needs of the nation's elderly began with the passage of the Social Security Act of 1935. It was a program with noble ideas that 50 years later, still serves as a reminder to those sentiments. The White House Conferences on Aging held every 10 years since 1951 represents the nation's continuing concern for our elderly population.

The concern for this population was heightened with the passage of the Hill-Burton Act in the early 1960's. It was a signal to the country that the nation's "aging policy"was the development and provision of nursing home care, or services being equated to institutionalization. A short 4 years later, the Older Americans Act was passed in 1965. In the same year, the Medicaid and Medicare program was passed by the Congress of the United States. While the Medicaid and Medicare program related to the continued provision of institutional care to the nation's elderly population; the Older Americans Act represented a change in policy: the provision of services designed to prevent and delay the onset of institutionalization. In 1971, the Amendments to the Older Americans Act created a national aging network with the creation of the State Units on Aging and the Area Agencies on Aging. These aging network was charged with the development of comprehensive and coordinated service delivery systems at the local level. Today, the Area Agency network consists of 664 area agencies on aging and 50 state Units on Aging, and state unit on aging equivalents for the trust territories. In 1975, the Older Americans Act was amended to provide Indian Tribes access to the aging network. This amendment allowed Indian tribes to receive funding directly from the federal government if they could prove that they were not receiving services from the state or area agencies. The rules and regulations, however, were never promulgated and as a result, no Tribe benefited from this amendment. Consequently, Indian Tribes pushed for the creation of a separate title within the Older Americans Act that would enable them to receive funding directly from the federal government. In 1978, Title VI became a part of the Older Americans Act, 13 years after the rest of the country had gotten its taste of aging program development and delivery.

It is a history that indicates a willingness to be responsive to the plight of the nation's elderly population. Concurrently, it also reflects a like concern for the unique concerns and circumstances of the country's Indian aging population. The evidence is readily apparent: 123 Indian tribes currently are recipients of Older Americans Act Title VI grants, Nutrition programs exist in every Indian community receiving these funds, and an increase in life expectancy of ten years for the Indian population as a whole. While gains have been made which can be verified through empirical data such as those mentioned, the seriousness of the unseen problem is alarming. The creation of "comparable service delivery systems, i.e. 123 Indian aging service providers, are not adequate and valid indicators of "progress" and "equity". If anything, the problems facing the Indian elderly have increased. In the area of health, Indian elderly are living longer (quantitatively), while concurrently, they are living in dismal conditions(qualitatively). In a recent *Wall Street Journal* article, it was revealed that in the past 6 years, Blacks have lost ground in terms of real income earned and, in fact, the gap between whites and blacks had increased dramatically. If the results of this finding is juxtaposed to the Indian community, it is very likely that the Indian community has fared worse than the black population.

This hearing has been entitled, *The Continuum of Health Care for Indian Elders*. A "continuum" presupposes range of conditions. In this instance, it refers to the health status of older Indian people. It is conceivable and practical to classify cohorts of Indian elderly subpopulations into a variety of convenient categories: "well elderly", "moderately impaired elderly","severely impaired elderly", and the "totally impaired elderly". Additionally, "continuum of health care" implies the availability health care services that range from preventive to high-intensity care services. Moreover, it also implies the existence of a "system" that is coordinated, dynamic, comprehensive and, above all, responsive to the impairment levels previously delineated. Lastly, it implies the existence of a sanctioned directive at the national level that serves not only as a programmatic agenda, but also as a philosophical foundation. These points have been explicated to provide the basis for the following remarks.

In order to take charge and provide policy directions, one must consider current circumstance and characteristics of the Indian elderly population; a description of the existing Health Care delivery system; and the identification of the various service delivery actors and their respective responsibilities.

A national survey conducted by the National Indian Council on Aging in 1981 provides a source of information on the characteristics of the nation's Indian elderly population. The Indian elderly population grew at a 71% rate between 1970 and 1980; or from 63,000 to 109,000. By 1990, that population is expected to double to well over 200,000. In terms of chronological age, elderly for purposes of this hearing is interpreted to mean 60 years of age and over. This elderly population represents 3/10's of 1 percent of the country's elderly population and 8% of the toal Indian population. This national study used a research instrument that was developed at Duke University to determine "impairment levels". The instrument was divided into 5 areas: Social well-being, Economic well-being, Mental well-being, Physical well-being, and Activities of Daily Living (ADL). A rating system of 1-6 is utilized with "1"being "Excellent" and "6" being considered "Totally Impaired". This rating is done in each of the five areas of the instrument for a possible total score range of 5-30, with "5" being excellent and "30" being totally impaired. By using this quantitative method, an accurate indicator of the categories of impairment can be established. In the national study referred to previously, approximately 26% of the nation's Indian elderly could be considered either "moderately or severely Impaired", or approximately 26,000 elderly Indians considered "at risk" of being institutionalized if supportive services are not provided. There are more females than males who are elderly; almost 32% of the elderly were categorized as being "moderately, severely, or totally impaired" with 57% reporting that they could barely meet their regular expenses and an additional 8% indicating that they could not meet their expenses; finally, 24% and 28%, respectively, indicated they had poor to no hearing or sight. In 1974, data released by the Indian Health service regarding the causes of deaths among Indian people revealed that Indian people between the ages of 45 and 59 died from accidents and cirrhosis at a rate of 16.9 and 13.7%, respectively, compared to 5.3% and 4.9% nationally. These two causes accounted for almost one-third of all deaths for that age cohort. In terms of geographical distribution, 85% of all Indian elderly residing on reservations were west of the Mississippi River; while nationwide, 52% of all Indian elderly lived on Indian reservations and 48% lived in urban areas.

In preceding panels of this hearing, witnesses have described the health care delivery system within their communities. In most of these revelations, it has been pointed out that there are gaps existing within these systems. The health care delivery system available to the Indian elderly consists of the Indian Health Service, an agency charged with the delivery of high-intensity medical care. It is an agency that is characterized by its rigid bureaucratic tendencies whose primary emphasis has been on the provision of medically-oriented maternal or pre-natal care. They represent the one extreme of the continuum, the health care provided within an institutional setting. Another component of the health care delivery system is the financing aspect of the health care delivery system. This service is represented by the Medicaid and Medicare program. This program is administered by the Health Care Financing Administration. The "gaps" that appear within this health care delivery system as it relates to the Medicaid program is partly attributable to it being a state program and thus differs from state to state. In Arizona, the Medicaid program is not available since the state opted not to participate in the program. As a result, Indian elderly in Arizona do not benefit from Medicaid. Nationwide, only 26.4% have Medicaid coverage. In both Medicaid and Medicare,services and payments are mainly for the payment of institutional care services. Again, these are services located on the extreme end of the continuum and, in most instances, the most costly. Although the Medicaid and Medicare programs pay for Home Health Care services, the availability of Home Health Agencies are practically non-existent in Indian communities. There are,for example, only three Home Health Agencies that are federally-certified on Indian reservation that I am aware of. These are located on the Zuni and Navajo Reservations, and the other is in Nevada through the InterTribal Council of Nevada. In most instances, the lack of qualified staff within the area precludes the creation of Home Health Agencies on Indian reservations. Internal Indian Health Service personnel policies preclude the use of medical professionals outside of the medical institutions by counting only those hours that are spent providing medical care within these institutions. In other words, IHS physicians' time providing health check-up activities at a senior center counted as part of the IHS-paid time. Therefore, preventive health care is discouraged, which is the least costly; while encouraging the elderly to wait until their health problems worsen to the point of institutionalization or even their death. While the emphasis of the current health care delivery system has been on the extreme end of the continuum, its emphasis has also been in the delivery of acute medical care and not in convalescent care as provided in nursing homes. Nationwide, there are nine Indian nursing homes on Indian reservations with a total bed capacity of 410 beds. Studies by researchers in the field have pointed to the need of 5% of the elderly population requiring nursing home care, or 5,450 of the nation's 109,000 Indian elderly. Most of this institutionalized population are in non-Indian nursing homes away from their homes, families, and culture. It would be preferable to many to remain in their own communities, even if it is in a nursing home setting. Yet, that option is not available to them. According to the Indian Health Service, nursing home care is not an authorized activity and IHS is "not to be involved in the nursing home business". With the growing number of Indian elderly and the concomitant need for nursing home care, IHS' position of non-involvement in this crucial area is and will be a serious oversight with costly implications and ramifications. Another crucial member of this "system" is the Bureau of Indian Affairs (BIA). Their role within the delivery of health care is nil. It is BIA's position that it is IHS's responsibility to provide this type of care. A most critical member of this "system" is the aging network established by the Older Americans Act, Title VI programs. However, with the limited level of funding to tribes, Title VI programs have been used mostly to provide nutrition programs, an important aspect of health. In addition to it being monotonic in its services, Title VI in most Indian communities provides only one meal aweek to its elderly beneficiaries. One meal a week will not ensure the continued good health of elderly people, much less anyone. Since the services being provided under the Title VI program is used mostly for nutrition programs, the development of services designed for the "at risk" elderly goes by the board. In light of the preceding testimony, does a Continuum of Health Care exist within the Indian community? It is my opinion that it does not. A system connotes coordination, comprehensiveness, and responsiveness and it is obvious that this "system" does not. Community-based health care services such as HomeHealth care, Adult Daycare, Respite Care, Chore Services, Outreach and Evaluation services, and case management services are either non-existent or practically non-existent.

Who are the actors ? To which group of elderly people are they responsible to? In the proceeding paragraphs, these will be identified and discussed.

The actors involved within the service delivery activities are the following: 1) the individual: 2) the tribal government: 3) the state government; 4) the federal government; and 5) the Congress. These are the actors that are part of the process which will result in the verb, "taking charge".

The individual is the elderly person. It is their responsibility to ensure that they are a part of this policymaking process. Too often they allow others to make decisions on their behalf To ensure the development of the Health Care delivery system, they must be incorporated into the process of needs identification, In this approach, there must be a formally designated process of gathering these viewpoints. Advisory Councils composed of elderly should be required of every program that impact the life of the Indian elderly. It is not enough to mandate the creation of advisory councils and anticipate that the contributions made by them are the result of an educational osmosis. The provision of training funds to train the advisory councils is necessary. Without them, they would continue to remain passive and easily intimidated by program directors etc. In the final analysis, it is the individual elderly who is responsible for the maintenance of his health. The use of peer group pressure in developing healthful lifestyles is an innovative way of behavior modification. Funding of the Title VII program of the Older Americans Act should be structured to enable Indian Tribes to share equitably in the programs.

At the tribal level, it has been my experience that program directors are an expendable commodity. As a result, most aging program directors are inexperienced and lack the knowledge to begin to design and implement comprehensive and coordinated service delivery systems. Too often, tribal governments look to aging programs as a way of capturing indirect costs that would continue to support their administrative costs. As a result, program dollars are diverted to cover administrative costs instead of hardcore services. Rather than expanding services to elderly, tribal funds that were used the year before are sometimes decreased even though there is a prohibition against supplanting and a provision for "maintenance of effort". Tribal officials need to become more knowledgeable about the programs for their elderly. It is possible that this could occur wherein each tribe be require to establish Tribal Units on Aging similar to State Agencies on Aging. These Units on Aging should be a distinct agency and with authority granted by the governing body to be the planning and coordinating body for aging programs. All too often, I have encountered instances where the biggest problem has been the battle for "turf". By statutorily requiring this authorization, aging programs will be in a positon of strength to ensure the development of a comprehensive and coordinated service delivery system.

State governments, by law, have a responsibility to its elderly citizens. Indian elderly are imbued with a unique citizenship status. In addition to being citizens of their tribes, they also have citizenship status within the state. Therefore, funds made available to States for social service programs shall require setasides for Indian Tribes in the state. Since the enactment of the Title XX Social Security Act programs in 1975, tribal governments have, for all intent and purposes, been excluded from participating in this program. Medicaid programs should be made more readily available to Indian elderly. These programs should be made available to Indian tribes without regard to the state's involvement.

The creation of a national commission of Indian aging concerns at the federal level is an initial step in the development and implementation of comprehensive and coordinated strategies in the delivery of services to Indian elderly people. Its precise purpose will be to monitor and assist,in a process designed to comply with Indian needs, the strategies developed. Funding is crucial to Indian aging programs and therefore, funding should be increased for : Title VI of the Older Americans Act; Title XX of the Social Security Act; Title IV of the Older Americans Act; and statutory requirements for both BIA and IHS to begin service delivery strategies and intiate its service s for the elderly.

The Bureau of Indian Affairs, the Indian Health Service, and the Administration should be required, by statutue, to establish Indian Aging Desks. Its purposes would be to develop coordination linkages among and between the primary "Indian" federal agencies.

The Congress' role is one of overseeing where Indian aging is headed. This direction should be based upon an Indian philosophical basis, like the National Indian Aging Policy. Its adoption and passage will provide a blueprint for service delivery systems for years to come. I believe Indian aging is not a unique phenomena.
I believe that the Congress of the United States should sponsor an international indigenous aging conference in 1990. This conference will enable the exchange of information among indigenous peoples of the western hemisphere.

These then, Senator Bingaman, have been my thoughts regarding Taking Charge. I have every hopes that they have been useful to you as you ponder the needs of the Indian elderly. If there is anything that I can be of assistance to you, please let me know. Thank you.

Senator BINGAMAN. Thank you very much, Larry. I appreciate it.

Our final witness is Paul Nathanson from the Institute of Public Law. Paul, we're glad you're here. Look forward to hearing your testimony.

STATEMENT OF PAUL NATHANSON, ALBUQUERQUE, NM, DIRECTOR, INSTITUTE OF PUBLIC LAW, UNIVERSITY OF NEW MEXICO

Mr. NATHANSON. Thank you very much, Senator. It is a pleasure to be here. I feel a little bit out of my depth in that I've been asked not, as the rest of the witnesses today, to speak specifically about Indian aging health issues but rather to give a broader perspective on national aging health issues in general. And I have done that, pointed out various problems and pieces of legislation that ought to be supported at the national level in the written testimony that I have submitted, and in the interest of really having you finish on time, I will very briefly make some general comments.

As you indicated, I'm currently with the University of New Mexico School of Law and director of the Institute of Public Law. I'm the immediate past president of the American Society on Aging, which used to be the Western Gerontological Society, and prior to that was executive director of the National Senior Citizens Law Center in Los Angeles and Washington, DC. I feel honored to be here today with some old, long-time friends, Larry Curley, Bill Benson and others that I have worked with over the years, your excellent staff. In another life before that time I was a tax lawyer with O'Melneny & Myers in Los Angeles. In which case I didn't see very many poor, old people, but that's another life.

When I came to New Mexico, I feel—I was fortunate—as I was able to, for the first 3 years here, be involved in running an elderly law clinic in northern New Mexico providing legal services to elderly Indians and Hispanics in rural villages in northern New Mexico. I feel like that gave me a wonderful chance at a good perspective that I needed—given the other work that I have done.

I would like to commend you for holding these hearings and briefly go to some general comments. First of all, I think your involvement, Senator, in health issues nationally is to be commended. I think you focused on what has to be considered the emerging field in the next 20 if not more years. We're hearing it all the time in the context of cost containment, new delivery systems for health care and new focus, so that this is very timely and your focus on this particular subgroup, of course, is most appropriate, especially in this State.

At the outset I want to commend you specifically for being a sponsor of a piece of legislation, S. 2576, which as I understand it, is designed to speed up Medicare claims payments by HFCA. And it brings up an important point, which I think we as advocates tend to forget. That is the Congress can oftentimes pass wonderful legislation, but unless the bureaucracies, many of which we have heard from today, are also of like minds, the intended beneficiaries don't really receive what you and Congress intend. We need as advocates—and I think you in the Congress and Senate, if it's not too presumptuous of me, need to maintain these kinds of efforts to stay after the bureaucracy to make sure that they're doing what you in Congress have intended.

I'm reminded—as many of you may be familiar with—of the situation in which the current administration in Washington in the face of numerous circuit court—Federal, circuit court decisions tried to cut people off the Social Security Disability Program contrary to those decisions; and it took a long battle and long congressional, legislative monitoring before the bureaucracy came into line.

We unfortunately or fortunately, depending on your point of view, live in a claims based society. Unless you know about benefits and have the means of enforcing them—I know this is sort of a lawyer's pitch, but I think it's important—unless you tell people about what's available once you have passed it back in Congress, unless you think about self-enforcing mechanisms and providing enough funding so that the programs that you designed can really get out to the people, it's almost like a tree falling in the forest and no one there to hear it.

Although I know the focus here today is substantive legislation, I think it's very important to focus on enforcement and on telling people about the benefits. I'm reminded of one more appropriate anecdote regarding the SSI claims manual for the Supplemental Security Income Program. When it first came in, the claims manual that is used by the Social Security district offices, in describing one of its benefits, the $100 emergency advance payment to the district workers told the workers "Don't tell them about it unless they ask." Don't tell the beneficiaries about it unless they ask. Obviously this is something which is now changed, but the approach was "Hold on to the dollars; don't be out there spending them."

The increased cost of health care has been much on the national agenda. I think you need to be thinking about some very hard questions. The rationing of health care. How do we do it, if we do it? In England if you are over 55 years of age you cannot get kidney dialysis. Now, when I tell that to my students in law school they're shocked. But there is a rationing of health care under the National Health Program based on chronological age. Is that something we ever want to look at? I was fortunate enough to go to China several years ago. We asked them about doing bypass surgery, and they said: "Oh, sure, we can do it, but we don't. We don't have the dollars. We spread it a lot more broadly. That's the kind of care that we've just decided not to give." I think that we're going to have those very tough questions, those ethical questions on our agenda.

Governor Lamb, I must say I disagree with his statement which I think was designed to get press coverage. He knows the difference between a "duty" to die and a "right" to die. He ought to know anyway as a lawyer. The concept, however, is important. People are talking about this, so I think we need to know what are the views of elders in the society. I think we might well be surprised that many older people would say, "Yes, I agree with this public policy. I disagree with that one." But we ought to at least be out there at some, perhaps, future hearing asking the views of the population as to—the specific population that's being talked about—as to the resource allocation based on chronological age. I think the thing is coming. It's just how we slice it.

I know another very tough question that you're going to get a lot of debate on from all the aging organizations—I know I'm being heretical here—is the issue of need versus chronological age criteria, that is means testing in some form or another. With limited resources, do we look at whether the most needy should get certain services. My father would be very mad with me if he knew I was saying this, but the fact is that he doesn't need a lot of the benefits that are provided for him currently by the Federal Government. I think he might well give up some if it was done in a general way. I think the aging organizations should be in the forefront on this issue. They should be looking at how to deal with the neediest. As I say it's a very tough question.

The right to die issue, as opposed to the duty to die, are obviously much on the national agenda. As I understand it, there is a Senate Committee on Aging report which hopefully is to be published—which I commend, its an excellent job—discussing the increased use in national health care setting of the durable power of attorney, organ transplant legislation. These kinds of things revolve around the ethics of medical care. I would caution, however, that when you're dealing with specific populations, such as Indian elderly, Hispanic elderly, anything that we in the general population might think is very avant-garde and forward looking needs to be specifically sensitive to cultural background and value systems—especially when you're dealing with the dying. There are great differences in the people about whom we're talking.

Some specific issues—I know I'm already overtime; I apologize—that I think need further exploration and are being looked at, at least by some, is the quality of nursing home care. A recent Institute of Medicine study points out the need for greater enforcement. Again, we've got regulations on the books. We have got the statutes on the books. How do we enforce them? What kinds of enforcement? How do we avoid—this runs throughout a lot of general health programs—discrimination against people based not on race or color but on who pays for their care. How do we deal with those being paid for by Medicaid being refused admission or being transferred from one home to another. That's a State issue. It's also obviously a Federal issue.

One tiny point, but I think a big leap for a lot of older people in nursing homes, would be to support legislation which, I believe, Senator Heinz has introduced—the chair of your committee—to increase the personal needs allowance in nursing homes from—I think it's $25 a month. People living in nursing homes since 1974, who are living on Medicaid, have been allowed $25 a month to spend on whatever they want, and not to be spent foolishly, of course. The hope is, perhaps, that could be increased to $35.

A couple of other caveats. I mean—a very hot topic is, of course, financing long term care. We heard the excellent testimony today. A lot of the people are looking at insurance programs. My warning there is—I think we need to be creative about how we finance long term care, but a lot of proposals are coming out of private sector oriented bodies and pushing IRA's and various other self-insurance policies, many of which will not work for poor people or near poor people. I think that we should not get caught up in the euphoria. I think there are some very good ideas here, but I would hope we do not get caught up in the euphoria assuming everybody can afford a health care IRA, or everybody can afford long term care insurance. We obviously need to worry about protecting the poor and the near poor.

In my rural northern New Mexico experience, I think the issues are the same. In Penasco, Taos, or Pecuris, it's access to health care. If you're far away from the hospital or clinic, then you've got transportation problems. This goes for anglos as well as Indians or Hispanics in northern New Mexico.

The other issue is how do we get health care practitioners to want to go to rural areas. I can't understand why they don't want to go to Penasco, because I love it up there. How do we provide incentives for health care practitioners to leave the city and go out into the rural areas?

The other issue in the North, the same again as you have heard today, is that the people want to stay at home. They're culturally tied to land. You know, I moved to New Mexico, as I said as a newcomer in 1980, and land was sort of a commodity. You sell it. You buy it. But there are cultural values here that don't understand that kind of perception—you don't leave the land. You don't leave your home. We need to be especially sensitive to the fact that it's more than just a convenience to keep somebody at home. It may actually be a spiritual need that has to be dealt with.

Finally, from the perceptive of an educator I would push that the institutions of public learning, higher learning in the State, start focusing more on gerontological education. I understand that the Health and Human Services Department is about to give a grant to the University of New Mexico School of Medicine, which you have been very supportive of, to provide training to health care providers. The University of New Mexico and New Mexico State are working together to try to finally see some sort of expanded gerontological education effort. Things are happening—but more work needs to be done.

Thank you.

[The prepared statement of Mr. Nathanson follows:]

Hearing on Continuum of Health Care for Indian Elders
U.S. Senate Special Committee on Aging

Santa Fe, New Mexico
September 3, 1986

Testimony of Paul Nathanson
Research Professor and Director
Institute of Public Law
University of New Mexico
School of Law
Albuquerque, New Mexico

Paul Nathanson
Testimony, September 3, 1986

Senator Bingaman, it is a pleasure to be here today and to provide testimony on national health issues of concern to the nation's elderly citizens. I would like to commend you for holding these hearings, and for once again showing your concern in this most important arena of public policy.

I am Paul Nathanson, Research Professor of Law and Director of the Institute of Public Law, University of New Mexico School of Law. I am the immediate Past President of the American Society on Aging, a founding member of the ABA Commission on Legal Problems of the Elderly, and an advisory panel member for a recent Office of Technology Assessment study on the public policy implications of dementia. Prior to coming to New Mexico, I was (from 1972 - 1980) the Executive Director of the National Senior Citizens Law Center in Los Angeles and Washington D.C. Since coming to New Mexico in 1980, I have taught courses on legal problems of the elderly, and have conducted a legal clinic in northern New Mexico focused on aiding elderly Indians and Hispanics. This wonderful experience of working with elderly people in rural northern New Mexico has added a much needed perspective to my prior work.

I have been asked to provide some comments on national issues in the field of health and aging. Thus, my testimony today does not focus on specific needs of the Indian elderly, which will have been addressed by others testifying before you today.

Paul Nathanson
Testimony, September 3, 1988

I would like to note that the following comments are intended as a brief listing of topics of concern, and it is my understanding that since the record will remain open for some time, these remarks can be expanded and amplified at a later time, should there be a need.

Senator Bingaman, before listing these issues, I would like to make an initial point. As recently as July 23 of this year, you showed your compassion for the nation's elders by co-sponsoring S. 2576 to require timely payment of Medicare claims. The slow-down in processing such claims, fostered by cost-cutting measures of the Executive branch, show once again how vulnerable are the elderly and poor who must rely for their basic necessities on giant government bureaucracy. An even more blatant example is the Administration's attempts during recent years to cut large numbers of Social Security disability recipients from the rolls, even in the face of contrary U.S. Circuit Court opinions. All this goes to show that even where Congress has acted favorably, an Administration and bureaucracy intent on cutting social programs can be a formidable foe. We advocates for the poor and elderly should not lose sight of the fact that merely to have positive legislation (whether in the health, income, housing or social services spheres) is not enough. We must make certain that Congress' beneficent intent is carried out by the appropriate agencies.

I. National Health Policy Issues

A. There is a lack of consensus about the nature and extent of public responsibility for meeting the health needs of the population in general. Symptomatic of this lack of consensus is the fact that twenty to thirty million persons in this country do not have health insurance of any kind. The issue of uncompensated care and the access to care problems created by it raise significant moral and ethical dilemmas and, in some cases, legal issues.

B. Long-term care has emerged as one of the foremost and most difficult policy problems we are currently facing in this country. While substantial resources are presently being directed toward long-term care, demographic trends indicate that the future demand will be significantly greater.

C. With respect to the provision of long-term care, no consensus yet exists as to what the appropriate roles and responsibilities should be for the public and private sector, the latter including the families of those individuals requiring long-term care. In addition, within the public sector, agreement has yet to be reached as to the relative responsibilities of the different levels of government--federal, state and local.

D. The programs that currently exist for providing health care services (Medicare, private health insurance, etc.) are oriented to acute care, particularly hospital and physician services, rather than to a continuum of care encompassing a range of health and social services. The orientation of the American health care system is not well matched to the service needs of the chronically ill and disabled. This is having serious consequences for the aged and their families, both because many service costs must be borne directly by them and because many services simply are not available. Pressures are mounting to move away from traditional medical-model institutional approach to caring for the needs of the frail elderly and the physically disabled to more open, community-based approaches which maximize the independence of the individual.

II. Health Care Costs, Quality of Care and Medicare

Continuing, excessive cost escalation in the health sector of the economy and the correspondingly rapid increase in the cost of Medicare played a major role in the creation of the Medicare prospective pricing system (PPS). Although PPS has contributed to a slowing in Medicare inflation, there are significant incentives in the system to skimp on care and to shorten the length of a hospital stay. Suddenly the public outcry against rapidly rising health care costs has been supplanted by public concern that the quality of care has rapidly declined.

The significance of the impact of rising health care costs on older Americans cannot be underestimated, despite the current concerns about quality of care. Medicare's coverage of health care needs, while adequate in some areas, leaves the beneficiary at considerable risk in others. Overall, Medicare pays for less than half of the older person's total health care bill. An out-of-pocket liability is considerable and growing. For example, Medicare's cost-sharing requirements continue to increase. Additionally, beneficiaries experienced an 80% increase in their out-of-pocket liability for non-covered services and products between 1978 and 1981. Increases in health care costs pose special problems for the elderly poor/near poor. A Health Care Financing Administration study found that out-of-pocket expenses expressed as a percent of income were six times greater for poor/near poor older persons than for their middle income counterparts. Moreover, fully one-fourth of the elderly poor/near poor are not protected by Medicaid. It is clear, then, that cost continues to be a significant issue for many older Americans.

The tremendous national concern for quality of care has become paramount as strategies for the containment of health care costs have been implemented. Evidence from the Medicare system demonstrates that incentives to reduce the hospital cost of each inpatient stay and to increase the number of inpatient admissions can adversely impact quality of care. Efforts to quantify quality of care have amply demonstrated that the methods for assessing quality of care must be improved. Until such improvements are made, extensive monitoring of the system is necessary to protect patients. Currently, remedial legislation has been introduced to address some of the quality of care concerns brought about by the prospective payment system in Medicare.

The changes in the Medicare payment system also focused attention on significant gaps in our health care system--the post acute care system. Patients deemed to be no longer in need of acute care services are frequently in need of skilled nursing care or home health care services. The problem is that these services are not always available. When they are available, the beneficiary is frequently in a position where the services are not covered by Medicare. The beneficiary is then placed at risk for the cost of these services. Public attention is currently being focused on the growing number of inappropriate denials of coverage by Medicare.

III. Miscellaneous Health Issues

A. Quality of Nursing Home Care

The Institute of Medicine recently released a study showing that much work still needs to be done to improve nursing home care and quality of life. Specifically, the IOM study recommended: 1) All nursing homes be required to follow certification requirements for Skilled Nursing Facilities; 2) Actual assessment of nursing home performance as to quality of care; 3) Amending Medicaid law to provide for intermediate sanctions (short of decertification) for non-compliance; 4) Expanded federal support for the ombudsman program and other consumer efforts.

Currently pending legislation introduced by Congressman Claude Pepper (H.R. 4485) would provide significant protection for nursing home residents regarding these issues. H.R. 4485 also provides for: protection against discrimination in admission, transfer, discharge and service based on source of payment; private rights of action in federal court to enforce statutory Medicaid requirements; and criminal sanctions against nursing homes for gross negligence.

Senator Heinz, Chair of the Senate Special Committee on Aging, has introduced legislation -- long overdue -- to raise the personal needs allowance for nursing home residents on Medicaid from $25 to $35 a month. The current allowance provides a meager 82 cents per day and has never been adjusted for cost of living increases since its inception in 1974. Obviously, such legislation should be supported.

B. Medical Malpractice

Much is being written and discussed about this issue, but it is unclear what its impact on the elderly is. Reforms currently being proposed may only limit access to the legal system for those most in need of help. Reforms may inaccurately lump together very divergent categories of people, such as persons over 65 years of age and upper income, with persons 60 years old, unemployed and near poor.

Finally, we need to know whether physicians are leaving practice in rural areas with high percentages of elderly citizens, or are leaving medical specialties of special concern to the elderly.

C. Financing Long-term Care

The true catastrophic expense for older persons is the financing of long-term care services. Recent attention to long-term care insurance as the solution is probably misplaced. Such insurance would most likely be unattainable for the poor and near poor. A disproportionate amount of Medicaid money goes toward long-term care, particularly institutional care. What should be the government's response in this area? A recent OTA study indicates much room for improvement in coverage by Medicare and Medicaid in the long-term care of patients with dementia.

D. Ethical Issues in Health Care

There are many ethical issues in health care that need to be raised. Of particular note are decisions about who gets treated and what kind of treatment will be available in light of dwindling public health care resources. For the poor, access to primary health services is at stake. For the elderly, the rationing of advanced medical technology may be at issue.

Much has been recently written about the "right to die" and control over one's own health care decisions. A U.S. Senate Special Committee on Aging publication makes several worthwhile recommendations in this regard. Thus, it argues for the expanded use of: dual powers of attorney, living wills, right to refuse treatment and organ donation legislation in federal agencies operating health care facilities.

E. Health Promotion and Disease Prevention

As an effort to contain health care costs, health promotion and disease prevention have received renewed attention of late. You, Senator Bingaman, have certainly been a leader in this regard. What must be realized is that to be effective, educational programs must be implemented for consumers as well as for health professionals. Additionally, monies and services must be made available for preventive health care in the community.

F. Trained Geriatric Personnel

With the percentage of the population over 65 increasing dramatically, and the over 85 even more significantly, there is a growing need for trained geriatric personnel in the medical profession. Medical schools must make greater efforts to encourage a curriculum that would sensitize physicians to the problems and needs of an older population. The emphasis of such physicians should be on managing the care of older individuals frequently with one or more chronic conditions rather than on "doing" things to them.

G. Caregivers

The nation's caregivers, primarily women, suffer under the stress of providing long-term care services. Public and private programs must be focused on this reality and designed to aid in its solution.

H. Catastrophic Illness Insurance

An advisory panel for Health and Human Services Secretary Bowen has recently made far reaching recommendations regarding a system to cover costs of catastrophic illness. This is another area in need of legislation from Congress. Worthwhile proposals to involve the private sector should always be evaluated in terms of how they will aid the poor and near poor.

Conclusion

Although we have seen that the health care status of many Indian elders is indeed drastic - and a national disgrace - the situation of many of the nation's elderly in general (especially the frail poor and near poor), is far from commendable. Thank you again for giving us the opportunity to highlight these needs. We look forward to working with you and like-minded friends of the elderly and poor in the Congress. We hope you can bring about the necessary changes so that in this great country the quality and viability of adequate health care for all will one day equal the care provided by most other industrialized nations.

Senator **Bingaman**. Thank you very much. I appreciate the time and effort put into the testimony that has been presented here today. All our witnesses have contributed greatly to our understanding of these problems. I think rather than go into more questions, at this point I will conclude the hearing and put everyone including the witnesses, on notice, that what we plan to do is to take the testimony, both oral and written, study it, sift through it, and try to come up with some specific recommendations, either legislatively or administratively. Then get back in touch with people and get their input.

I've sat through a series of hearings since I've been in Congress, and I think there is always a danger that you just have a hearing and when it's over with, you get the record typed up and figure that was good. But there is a lot more. I think if this process is going to be meaningful, and if all the effort that's gone into it by the witnesses and all the others is going to pay off, we really need to try to follow up on specific recommendations.

So I appreciate the testimony of these two final witnesses and all the other witnesses in trying to focus our attention on this serious set of issues. I do think that there are clearly gaps in this continuum of service that we have.

I just got a note here that says Alta Bluehouse one of our scheduled witnesses, has just arrived. She had car trouble, and was delayed. We will insert her testimony in the record [1] and make it available to everybody for their review, and possibly I can get a chance to talk with her a little bit before I have to leave today.

I think there are clearly gaps in the continuum of health care services for the elderly Indian citizens. The question is how can we fill those gaps. How can we try to coordinate the effort of the various agencies at all levels of government more effectively to fill those gaps and meet the needs. And I hope that when we summarize what's been said here, we can come up with some concrete ways to do that.

Let me just say before adjourning this hearing, we're going to show the video tape again which was shown before the hearing this morning. This is an excellent tape which I recommend that you all watch if you can. It takes 11 minutes. It's done by the New Mexico School of Medicine. Sally Davis and Ken Hunt, who are both here, have been working on this and really are responsible for getting this put together. It tries to go over some of these issues in the context of the Indian community. Why don't we start the tape. I once again want to thank all of you for coming.

[The foregoing hearing was concluded at the approximate hour of 3:10 p.m.]

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[1] See p. 207.

APPENDIXES

APPENDIX 1

STATEMENTS AND LETTERS SUBMITTED BY INDIVIDUALS AND ORGANIZATIONS

Item 1

NAVAJOLAND NURSING HOMES, INC.

INTRODUCTION:

I am Alta R. Bluehouse, Executive Director, Navajoland Nursing Homes, Inc. representing the Chinle and Toyei Nursing Homes. It is indeed an honor to be invited to this hearing by a distinquish individual, Senator Bingaman.

Presently, there are two nursing home facilities for adults and handicapped individuals on the Arizona portion of the Navajo Indian Reservation. Chinle Nursing Home is located two miles outside the town of Chinle, a small community located in the central part of the Navajo Reservation in Northern, Arizona. Toyei Nursing Home is located on the grounds of the Toyei Boarding School compound, 22 miles West of Ganado and 20 miles South of Keams Canyon, Arizona.

Our current population is 180,000 and the Navajo Indian Reservation is the size of West Virginia. As you see, our population is the largest among the Native Americans in the United States, which means age 65 plus is also in a great number. The two nursing homes accommodate 145 Indian elders. This speaks for itself that there is a definite need for more long term care services on the Navajo Nation.

HISTORY - CHINLE/TOYEI NURSING HOMES:

Chinle Nursing Home was constructed and open for operation in July of 1971. Funds for the construction of this facility were secured from several sources:

Hill-Burton	$ 741,616
Four Corner	105,000
Private	642,847
Total:	$1,489,463

This facility is a 79-bed facility and set up to provide nursing care services on a twenty-four hour basis to Skilled Care at that time and currently providing services to Intermediate and Custodial Care. Chinle Nursing Home was originally owned and operated by Dine Bitsiis Baa Aha Yaa, Inc., (Navajo interpretation for "To Care for the People's Health and Well-being", DBBAY, Inc.). This corporation was a private, non-profit corporation governed by a Board of Directors, composed of nine Navajos and one Non-Navajo. The Corporation also owned the Chinle Valley School for Children, Chinle Housing Project, and the Chinle Day Care Center.

In September of 1978, the Navajo Health Authority was asked by the Navajo Tribe to assume the responsibility of managing both the Chinle and Toyei Nursing Homes due to financial problems forcing the original owners to no longer be able to operate the facilities. Navajo Health Authority was forced to merge all programs into Division of Health Improvement Services with the Navajo Tribe which caused the termination of Navajo Health Authority as an organization on March 31, 1982. It was through this phase, that Chinle and Toyei Nursing Homes chose to become an independent non-profit organization and incorporated as the Navajoland Nursing Homes, Inc., governed by ten Board of Directors, composed of Navajos and Non-Navajos.

Navajoland Nursing Homes, Inc., is organized as a non-profit organization to provide nursing home services at the levels of Intermediate and Custodial Nursing Care. The levels of nursing care services is defined within accordance to regulations and standards of the State of Arizona, Health Care Facilities, Long Term Care Facilities, and also within accordance to the Navajo Tribal Nursing Home Code. The nursing home services are provided to Native Americans; the Navajos being the predominant majority clients representation; to a degree that reflects the highest optimal level of efficient and effective nursing home services although the funding is a major factor in terms of hinderance and progress due to limited funding.

Housing problems, lack of water and fuel, poor sanitation, inadequate finance, and lack of transportation contributes to the placement of persons in nursing homes.

In 1978, there were approximately 15,000 Navajo elders. Some 1,200 elderly and handicapped Navajo people were in bordertown nursing homes while only 79 Navajos were being served by Chinle Nursing Home, at that time the only nursing home on the Navajo Indian Reservation. Because of an acute demand for additional nursing home for custodial patients was needed, a proposal was made in July, 1977 by community leaders to the Toyei Advisory School Board to convert Toyei Boarding School Dormitory to a custodial care facility. Again, due to limited funding, we were forced to lease one of the BIA dormitories and converted it into a nursing home. Much renovation to the BIA dormitory took place and 18 residents were admitted on August 14, 1978. Public Law 93-638 Federal Funds were secured from BIA as start up funds to renovate the dormitory and purchase the necessary equipment. Through the support of Indian Health Services and Bureau of Indian Affairs, the Toyei Nursing Home was opened.

The need for nursing home care for Navajo people has become increasingly important during the last 30 years, as a consequence of modernization and the breakdown of the Navajo family. Formerly, elders had a secure place within the extended family; many younger members of the family are now moving away to urban areas to seek employment, education and for other reasons. The increased use of motor vehicles, and consequent injuries and deaths from accidents has also created a need for extended care facilities to care for elderly family survivors and those disabled.

Prior to 1971, some Navajo elders were cared for as far away as Phoenix, some 450 miles from the reservation. These elders were deprived of visits from friends, children, relatives, from home. They suffered from lack of communication with their Non-Navajo speaking attendants, nurses, doctors and so forth. Many were being denied freedom to practice their Navajo Traditional beliefs, simply because they were isolated from the reservation. They were also separated from practicing their traditional ceremony.

Due to limited funding, Chinle Nursing Home has been forced to operate with obsolete equipment. There has been no allowance for major equipment replacement. The facilities are currently operating with equipment that were installed in

1971 at Chinle and 1978 at Toyei. These are a few of many variables that have refrain Chinle and Toyei Nursing Homes from operating to the fullest.

It is imperative, that a crucial look be undertaken and that the availability of nursing home services for our Navajo people within their homeland be weight with utmost importance versus economical dollars for similar services in foreign bordertowns, cities, and states. I believe although it may be a tremendous cost, that is only righteous and out of self-determination that we strive to maintain our Navajo elders and handicapped of our culture heritage and promote harmony of peace of the last few days or years, they have left. Our beloved residents, have had to face traumatic experiences, several times in the past, of having to be transferred out to bordertown nursing homes or other cities throughout the states, and many have suffered the tragedy of a lonely death due to psychological and culture shock in a foreign surrounding.

FUNDING:

The Chinle and Toyei Nursing Homes are currently receiving PL 93-638 Federal Funding from the Navajo Tribe, Division of Social Welfare. Chinle Nursing Home's per patient day rate is $36.75 a day and Toyei Nursing Home's per patient day rate is $35.32 a day. These rates, however, are far below the Arizona State Standard rates.

RECOMMENDATONS:

On behalf of our beloved elders, I enter a heartfelt plea that the following recommendations for Chinle and Toyei Nursing Homes be considered:

1. An Indian Desk be establish at the Washington level for Administration on Aging, which will provide better funding mechanisum and some recognization of the long term care services on the Indian Reservations.

2. The technical and legal assistance in gaining a waiver status to gain direct funding from Congressional level.

3. To be labled as a priority health care delivery care services.

4. To properly establish routine financial responsibility from Bureau of Indian Affairs, Indian Health Services, and the Navajo Tribe, Division of Social Welfare.

5. Additional funding from the Federal Government for the expansion of long term care services.

6. An Elderly Welfare Act should be considered for Indian Elderly.

Thank you.

Alta R. Blue house

Alta R. Bluehouse

Item 2

JEMEZ-COCHITI-SANTA ANA-SANDIA-ZIA

FIVE SANDOVAL INDIAN PUEBLOS, INC.

STATEMENT OF MARGARET GARCIA
OF FIVE SANDOVAL INDIAN PUEBLOS
BEFORE THE SENATE SPECIAL COMMITTEE ON AGING FIELD HEARING
ON THE CONTINUUM OF HEALTH CARE FOR INDIAN ELDERS
SEPTEMBER 3, 1986
SANTA FE, NEW MEXICO

Mr. Chairman, I appreciate this opportunity to present written testimony to your committee today. My name is Margaret Garcia. I am the Human Services Administrator for Five Sandoval Indian Pueblos. I wish to present testimony on the status of health and respective health care of our Indian elderly served and represented by our organization.

Five Sandoval Indian Pueblos is an incorporated consortium representing five Pueblos located within Sandoval County of New Mexico. These five federally recognized tribes include the Pueblos of Jemez, Zia, Santa Ana, Cochiti and Sandia. The total estimated 1986 population of these combined tribes is 5,164 according to 1986 Census compiled by the Bureau of Indian Affairs, Southern Pueblos Agency. The tribe of Jemez is located as far away as 55 miles from Albuquerque, the largest and closet city, to Sandia located 10 miles from the city limits of Albuquerque.

Of the 5,164 population, 522 or 10.1% are considered elderly. This is determined by the age eligibility of the Administration on Aging, which is 55 years or older. In general, our elderly lack basic literacy skills and are either unemployed or work at seasonally work and are considered underemployed. Most who do work, work at jobs paying minimum wages or are marginally employed. Our elderly are primarily home, farm or craft workers who depend solely on social security or receive marginal support from community services. The average median income for the general population in our five Pueblos is $3,101.80 and considerably lower for our Indian elderly. This would establish that over 25% of our population lives at poverty levels. The highest percentage of population living at poverty

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levels is in Jemez Pueblo (51.7%) and the lowest is in Santa Ana Pueblo (4.0%).

The unmet health needs of our elderly has been and continues to be a concern of Five Sandoval. The primary health care provider is Indian Health Service. Medicaid and Medicare as third party resource is generally not available to our elderly. The greatest concern that we have is that IHS cannot always guarantee sufficient funds will be available for health care. Due to budget limitations, often health care is provided facilities outside IHS and require complicated eligibility and payment process. In order to achieve parity health care with the general population, additional and increased resources both in funding and manpower will be needed. The combined situations where our primary health care provider is likely to become short of necessary funds and third party resources of Medicaid and Medicare are unavailable to our elderly, places our Indian elderly in great jeopardy.

The leading cause of illnesses and death as observed in our aging programs is diabetes. This includes diabetes with complications of cataracts, or visual problems, hypertension with its related side effects, and heart disease. Other problems seriously affecting our Indian elderly are poor nutrition leading to other serious illnesses, poor dental health, pneumonia and arthritis.

Currently, our Community Health Representative Program, AoA funded programs of congregate meal sites, Title VI aging program and the IHS program of Health Education offer partial solutions to these illnesses and health conditions of our elderly. This is accomplished through direct services, indirect services, community health education, providing transportation and offering information with referrals to services and other programs. These programs offer help to our elderly which have impact on the general well-being and improved health of our elderly. However, this is not enough.

As the administrator of the elderly programs, the IHS funded programs of our Community Health Representative (CHR) and the IHS Diabetes - Health Education program offer the greatest assistance with the exception of direct health care provided by clinics and hospitals. These community programs and its staff offers an important community service and the strongest support to our aging/elderly programs. Unlike other federally-funded programs receiving a substantial and sole funding to one program often enough to provide comprehensive program services, the aging programs are not as fortunate. Program administrators must develop a "patchwork quilt" of services and be creative in their approaches in meeting all of the needs of our clients. Health is one of those service areas needing an array of different service providers. Not one of our elderly programs offers complete and absolute solutions to the health care area.

The following is a true example of providing assistance to an Indian elderly diabetic with many service providers and the kind of service provided:

Indian Health Service or Community Health Representative identify an elderly diabetic.

- CHR provides literature from IHS Diabetes Program on how to identify the disease, how to treat themselves, and necessity of proper nutrition, etc. Instructions provided in native language and FSIP Elderly Meal Site is notified of new diabetic participant. Followup is provided on appointments, medication, etc, as well as providing transportation. No other program within FSIP can provide transportation to our elderly for health care.
- IHS Diabetes Program provides health screenings, community health education and monitors class or orientation participation to tribal elders who are identified as diabetics. Works with tribal CHR program and elderly nutrition sites.
- Elderly Nutrition Sites, acknowledge the elderly diabetic, provides diabetic meals, encourages proper nutrition and adherence to guidelines established by IHS Diabetes Program on quantity and quality of meals and snacks, and provides support services to CHR program and IHS Diabetes Program.

This is oversimplified, but an accurate picture of services being provided. As detailed, if the current trend to cutback or eliminate any of the above services, our Indian elderly will surely suffer. This example did not include the possible and probable complications of diabetes. For example, this disease has side effects impairing life functions. Deterioration is twice as common of the retina in older Indians. Treatment of this condition is often not effective in restoring vision, however vision can be usually restored by surgery in diabetics with cataracts. This surgery is not considered an emergency or to relieve a life threatening condition. Therefore, often our elderly are told no money is available for this kind of surgery and to wait for surgery. Often due to shortage of surgeons for surgery, months will pass before an elderly can have the surgery. Or must wait until contract health monies are available to this type of surgery.

The major difficulty and concern is that among our tribes the number of diabetics is great and increasing. This creates an almost overwhelming load on doctors, nurses, dietitans, health educations and community health programs like the CHR program. This further needs examination should our elderly need dialysis due to complications from this disease. The need of dialysis or kidney failure treatment/surgery will require transportation if the family is unable to provide such. This again is provided by the CHR for treatment on dialysis machines whether in a IHS facility or a contract facility. With the increasing number of diabetics who have need or require this kind of service, this will make it difficult to provide optimal health services.

With the given examples with only one disease affecting our Indian elderly, the proposed cutbacks and exchanged IHS priorities could have serious repercussions to the health status of our elderly. The elderly health services and related services are in jeopardy in the Indian Health budget. Since elderly health care has a low priority with IHS, the reduction of budget will mean even less attention than before. The general trend of attitudes among federal agencies is that focus and priority is given to families and young children. The thought is that the agency put its services "where it will do the most good". In other words, services to its citizens who will be the most productive or have a future, whereby leaving elderly services as a secondary or last priority.

We wish to express our concern that this administration would implement with such insensitivity cutbacks that would seriously impede the capability of IHS to provide health care to our elderly. This is most critical since Indian Health Service is the primary and often sole source of health to our American Indian elderly. This is compounded by the budget priorities and affect by Gramm-Rudman Amend, as well as the complex usage and reduced funds by Medicaid and Medicare.

The following are specific recommendations as determined by the health status, needs and observations by our program administrators and elderly:

- We urge this committee to urge your colleagues to protect the CHR programs as this is the most important program to upgrade the health care and to prevent its decline to the critical state of the past decade. This program provides support to our elderly through transportation, health education, health screening, interpretation on medication instructions and usage and other related health care services. This has enabled our elderly to live longer lives and continue to be productive citizens in their communities.

- We urge this committee and your fellow congressmen to increase programmatic authority for the CHR program and to increase appropriations beyond the 26.5 million in FY 1986 base.(Maintenance level in HR 5234 or House report 99-174 which accompany HR 5234) In support of this program's effectiveness, we also concur this program be maintained in the IHS budget. We also concur that the non-emergency transportation is still essential to the provision of health care, especially to the elderly and those in rural settings. (Taken from FY 1987 IHS Justification of Appropriations Estimates Statement.)

- We urge this committee to further this congressional review of our Indian elderly access to Medicaid and Medicare programs. The complex application process, often impeded by eligibility by Social Security, language barriers, and New Mexico state government reticence to promote Indian citizen participation in these programs is quite serious. Both State agencies, HED and HSD should be encouraged to provide information on its application process and its services on a routine basis to tribal groups, like FSIP.

- We would also like to recommend to this committee that tribal consultation be allowed on the IHS Gap Study implemented by IHS for Congressional request for information. This study is highly important quantity and quality of services provided to Indians especially to Indian elderly. This study offers exaggerated third party resources in its budget recommendations which could have serious and negative affect on health services later.

- We also support and endorse the Indian Diabetes Bill (S.1988) and urge this committee promote its further review and passage. This bill would expand IHS efforts in the prevention, control and treatment of diabetes. Currently, the Albuquerque Service Unit has this select program and it has proven to be effective in our communities. This bill should also be provided new money as well as expanded to all tribes. We do not recommend the inclusion of Native Hawaiians within the definition of Native Americans.

- We also urge this committee to analyze further the impact that the DHHS, Resource Allocation Methodology (RAM) will have on tribal health programs, who provide the closest services to tribal elderly. This objectionable provision of RAM will reduce IHS funding to tribes and service units by 90% of the amount of outside resources. For example, if a tribe obtains $100,000 funding from Health Block Grants, WIC, Medicaid/Medicare or other health programs, IHS will reduce funding to that tribe by $90,000. Further by reducing access to and expenditures for contract health services, DHHS will implement the proposed reduction in contract health services. Many of the services needed by Indian elderly are provided by contract health care, this will have critical impact on Indian elderly. Therefore, we urge this committee to continue to protect this line item from elimination.

Thank you for your interest in our Indian elderly and our tribes appreciate your efforts in helping resolve and improve health care to our tribal elders. This concludes our prepared remarks and we would be pleased to respond to any questions you might have at this time.

Item 3

From:
The Office Of The
Picuris Pueblo Governor

PICURIS PUEBLO

Picuris Pueblo
P.O. Box 127
Penasco, New Mexico
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The Continuum of Services to
Native Americans Elderly of New Mexico

Senator Bingaman:

The points, recommendations, and issues that I will present reflect the concerns which effect our elderly program in Northern New Mexico. I am certain that others will represent and voice their opinions similar to what I will point out.

Presently the Pueblo of Picuris is located in Northern New Mexico, Taos County, we of the Pueblo's are the most remote and situated in mountainous terrain. Our program is monitored by the ENIPC, however we were one of the first Pueblo's who took advantage of the Elderly Program when it was initially introduced at the State level.

Presently we have one cook and one cooks helper and one Site Manager who provide the daily activities of the program-there is no activity on weekends or holidays.

My concerns are the following:

1. Indian elderly increasing in population from 64,000 in 1970 to 109,000 in 1980; and it is projected this population will increase to over 200,000 by 1990.
2. Based on the preceding sections, the Congress of the United States hereby establishes the following policy directives designed to meet the physical and mental health needs of the Indian elderly; their spiritual well being; their continued involvement and roles with society; and the implementation of a policy that is consistent; reaffirms and strengthens the concept of tribal sovereignty and self-determination.
3. Increase appropriations and develop a formula with input by Indian Tribes, to ensure that 10% of Revenue Sharing funds allocated to tribes are utilized to develop roles and services to the Indian elderly.
4. Indian elderly shall be afforded the opportunity to live their lives in comfort and dignity in their home communities.
5. Federal agencies including Indian Health Services, Bureau of Indian Affairs and Health Care Financing Administration provide financial and technical resources to develop Tribal capabilities in delivery of services.

6. Federal government needs to maintain flexibility by recognizing the wide diversity of Tribal conditions and needs.

7. The Congress shall require and mandate Indian Health Services to establish a health service delivery system that includes the provision of health services that meet the needs of the Indian elderly that will include the provision of:

    a. geriatic health care prevention and maintenance
    b. eye glasses
    c. ~~dentures~~
    d. hearing aids
    e. access to dialysis services
    f. community control of programs
    g. other prosthetic devices

8. An intergovernmental agreement shall be implemented that will delineate and clarify the responsibilities of the various levels of government in the delivery of health care to the Indian community, State and Health Care Financing Administration and shall:

    a. Assure that Health Care Financing Administration, Indian Health Services shall provide Training and Technical Assistance to tribes and Indian Health Services staff to maximize reimbursement available under Health Care Financing Administration programs and other third party resources.

9. The Bureau of Indian Affairs shall advocate on behalf of Indian elderly to Congress to obtain adequate appropriations to address their unmet transportation needs.

10. That a national initiative be implemented among and between the various departments of the federal government that will increase funding to construct senior center facilities and develop a national coordination agreement that will establish a communication network.

11. Increase funding to nutritional programs commensurate with need that will ensure the provision of services to at least 50% of the target population.

12. Increase funding and greater program flexibility by allowing Indian Tribes to develop criteria for eligibility; program definitions, and implementation based on local needs for the Low Income Home Energy Assistance Program, weatherization, and Housing and Urban Development programs.

13. That a national initiative be implemented among and between the various responsible federal agencies to ensure the protection of the Indian elderly from crime, fraud, neglect, abuse and exploitation which will include increased funding for personnel, training, crime prevention programs and the development of national legislation designed to reduce the incidence of abuse, neglect, and exploitation among the nation's Indian elderly.

14. Increase the availability of legal services to the Indian elderly by increasing funding, program scope of existing legal service programs; through the development of a national standardized tribal judicial system; and increase funding to ensure the availability of resources to enable Indians to enter the legal profession.

15. Redesign regulatory requirements and laws which clearly authorizes tribal governments to define and standardize eligibility/age requirements for formal elderly employment, volunteer, and Administration on Aging program continuation and expansion at the local level through tribal approval and increased Federal appropriations.

16. With input from Indian Tribes, State and Federal Agencies shall utilize the mass media to develop community education and public awareness as to the realistic and positive aspects of Indian Aging.

Other additional Concerns and Recommendations are also indicated below:

A. Federal Funds are cut, yet, the Senior Citizen population increases annually.

B. I feel the State Government is not contributing enough to Indian Senior Citizen Program, yet, because of the Indian population in New Mexico, the influx of tourist occurs. I feel the Indians are once again being taken, the State Benefits at 85% or more.

C. Our Native American elderly have to state their own fund raising to go places including meetings and conferences and still support themselves and their family from sales of Arts & Crafts.

D. I recommend a shelter center for the elderly at a centralize location or one at each community especially for those tribes that are remotely located.

E. There are many single elderly people on reservations both male and female. These groups depend on elderly feeding Centers for company and friendship with other members.

F. The Public should not compare non-Indian programs with Indian Programs, the overall general setting is a very big difference location, livelihood, culture, traditions, etc.

G. The minimal amount that Picuris can ask for in behalf of its program operated from the Eight Northern Pueblo would be about $240,000 to be distributed equally to eight tribes.

Thank you for allowing me to provide this information and concerns in behave of the Picuris Pueblo Elderly program.

Respectfully Submitted

Joe I Quanchello
Lt. Governor, Picuris Pueblo
Date: Sept. 3,1986

File

Item 4

FACTS: Indian population numbers just over one million with the number of Indian Elderly nationwide is growing.

1970: 83,000 over 60 years of Age

1980: 108,669 over 60 years of Age, 24% increase

The number (#) of Indian Elderly living below the National poverty level is also increasing.

The major health problems of the Elderly are diabetes, hypertension, and tuberculosis in some areas. Alcoholism, though few Elders are alcoholics, those alcoholics among, the middle age and younger generation contributes to abuse of the older Indians in this form: children or relatives take what financial resources the Elders have to satisfy their need for alcohol and drugs in some instances, leaving them without money to buy food and other necessities that would keep them healthy.

We all know that the U.S. Indian Hewalth Service is the principle provider of health services to the Native American Elders. There should be a National Indian Aging Policy developed in Indian Health Services in coordination with all the agencies and programs on Aging.

AGENCIES OF OLDER INDIANS - National Indian Council on the Aging, Title VI, Title IV:

TITLE VI is a Supportive and Nutritional Program serving congregate meals and Home-delivered meals to eligible older Indians.

Senior Citizens Centers: Elders gather there for meals and socializing with one another.

1) This Program is not understood by majority. There needs to be more information given to participating and non-participating Elders. Much can be done in these Centers.
2) Nutrition Education programs should be established to Senior citizens as well as service providers.
3) Some kind of incentive programs developed to get eligible Seniors to participate in the Centers. Some think it is a charity institution.
4) Staff members - more sensitive to Elder's needs, their personality changes, etc.

5) HEALTH SERVICES
There needs to be a coordinator of Health Services, possibly people such as Drs. , Nurses, Social Workers, Physical Therapists, Nutritionists, Dentists and even Psychologists and Medicine Men. All these Agencies should have knowledge in the field of Geriatrics.

6) OTHER SERVICES WITHIN THE IMMEDIATE AREAS:
CHR's, IHS Clinics, Health Fairs to name a few. Immunication Programs should be developed.

7) Develop Optemetric and hearing tests. Where needed provisions for eye glasses and hearing aids

8) Dental examinations - Dentures, etc.

9) There is a relatively high prevalence of cataracts in our Elderly. Education is needed in this area of concern.

10) Hypertension or high blood pressure is another health problem, not only among the Elderly but also among the younger people. Periodical high blood pressure screening should be done in the Centers or IHS Clinics.

11) Transportation - Improvement in this area is needed. A lot of times this is not available when needed. Members of families should be encouraged to provide quick or emergency help in getting patients to the Health Services.

12) Geriatric Ambulatory care services are needed to get emergency patients to hospitals. (Could save many lives.)

13) In the field of NUTRITION - Where there is a Senior Center, balanced meals are served, that's only once a day, maybe twice a day. There is need for programs on Nutrition by a Nutritionist -- lectures or films, especially as they relate to diseases of diabetes, high blood pressure or cardiovascular diseases.

14) There should be an incorporation of traditional foods in the menus.

15) Obesity is a great physical problem among our Indian Elders. We like to eat. Education on the dangers of this problem should be held.

16) Health Prevention

17) MENTAL HEALTH - Alcoholism Abuse, Intergenerational Program
" A HAPPY PERSON IS A HEALTHY PERSON" Love and affection is a great prevention of sickness and Mental problems.

Senator Bingaman this is my personal testimony and concerns of the needs of the Elderly - age 73.
Member, Isleta Advisory Comm. Mrs. Agnes M. [illegible]
Isleta Senior Citizen Center. P.O. Box 314
Isleta, N.M. 87022

Item 5

Albuquerque Urban Indian Elders, Inc.
8220 La Barranca Ave. NE
Albuquerque, NM 87111

September 19, 1986

The Honorable Jeff Bingaman
United States Senate
Senate Office Building
Washington, D. C. 20510

Dear Senator Bingaman:

On September 3, 1986, the Senate Special Committee on Aging held a hearing in Santa Fe, New Mexico on "The Continuum of Health Care for Indian Elders". It provided the Indian community an opportunity to share with you their concerns regarding the availability and accessibility to services designed to meet the health needs of Indian elders. You are highly commended for the concern which you have for the nation's elderly, and in particular the Indian elderly.

It is the purpose of this letter to submit for the record of the hearing previously referred to, the concerns that we believe were overlooked and need to be addressed; namely, the Urban Indian Elderly. We believe that their needs require the same attention and concern as that given to Indians residing on reservations.

In New Mexico, there is a total Indian population of 107,481. Of this number, 24,636 live in the Albuquerque area alone. This is equal to 23% of the State's Indian population! Yet, the health needs of this population was not a topic of concern at the recent hearing. If national statistics are extrapolated and applied to the Albuquerque Indian population, eight percent of this population would be considered elderly, or 1,890 Indian elderly residing in the Albuquerque area. This figure is larger than that of most of the Indian communities currently receiving Older Americans Act Title VI grants.

The health needs of this elderly population are similar to those found on most Indian reservation, i.e., diabetes, heart disease, the effects of otitis media, etc., but the similarities end there. In the urban area, this is compounded by the problems of language and cultural barriers. Thus, their access to health services is severely impeded. Recently, the Indian Health Service published proposed new eligibility requirements for the receipt of contract and direct health care from the Indian Health Service. We are greatly concerned that:

1. IHS would now determine eligibility for services based on a one-fourth degree blood requirement. This would have the effect of a federal agency dictating to the tribes as to who their members shall be. In Martinez vs. Santa Clara, the Supreme Court held that Indian tribes had the power and authority to determine membership.

2. Contract and direct health care would now be consolidated and provided on a "health service delivery area" basis. Health service delivery areas would be determined later based upon the wishes of the tribe(s) affected within the area. Urban Indian communities are left out of this process of consultation. It is likely that Indians residing in urban areas will be left to fend for themselves in obtaining health care.

3. The recent report of the Health Care Cost Containment Task Force created by the Governor of New Mexico indicated a "crisis" that will occur within the health care delivery system. (See The Albuquerque Tribune, September 18, 1986). How will urban Indians fare as IHS pushes them into this "crisis"? Not too well we believe.

A "continuum" suggests the availability of services designed to meet the impairment levels of Indian elderly. In the Albuquerque area, services made available to elderly Indians by the Older Americans Act Title III programs are minimal. A nutrition site that had originally been designated as "Indian" has now been "assimilated". The result has been the non-participation of urban Indian elderly in the program. Home-health care is not being utilized nor is it sought. In order to receive home-health care, a physician must order it before Medicare will approve payment. To see a physician is costly, and since most Indian elderly are in the low income levels, they can not see the physician; thus, they do not receive home health care.

It is obvious to us, and hopefully to you, that the urban Indian elderly of this country are in a precarious state. A re-definition of the government's responsibility to them is required. Only then can definitive inroads be made in improving their lives. The pitting of "urbans" vs "reservations" only exascerbates the problem: it creates divisiveness and suggests (requires?) reservation residence to receive benefits as Indians. Is this a new governmental policy toward Indians? If it is, it is one of actively encouraging segregation.

We believe that a provision within the Older Americans Act should be included which requires State and Area Plans to identify specific plans which will result in specified outcomes. For example, requiring Area Agencies to contract with minorities, including Indian organizations, service providers, et al. Additionally, to ensure that outreach efforts are instituted which will result in increased minority and Indian participants within the Title III programs.

Senator Bingaman, thank you very much for the opportunity to place our concerns before you, and we look forward to your favorable response. It is our hope that this information is helpful to you as you contemplate the problems facing our Indian elders - both Urban and Reservation. Thank you again.

Respectfully submitted,

[illegible] - Chairman   Merceline Grace
Albuquerque Urban Indian Elderly [illegible]   [illegible]
Be'va Smith   Jimmie B. Davis

APPENDIX 2

RESPONSES TO FOLLOW-UP QUESTIONS FROM HEARING—BY DEPARTMENTS AND AGENCIES

Item 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Honorable Jeff Bingaman
United States Senate
Washington, D.C. 20510

Dear Senator Bingaman:

Enclosed are the responses to several questions forwarded to the Department as a follow-on to your New Mexico field hearing on "The Continuum of Health Care for Indian Elders." Please forgive the delay in responding, however, as you can understand the several agencies involved in preparing responses were also necessarily involved with the legislative activities of the closing days of this Congress.

If we can be of further assistance, please let me know.

Sincerely yours,

Patricia Knight
Deputy Assistant Secretary
for Legislation (Health)

Enclosures

Q: How does the IHS view its responsibility to Indian elders? That is, if IHS is a general health care provider, how does it expect to meet the specialized care of Indian elders and the increased need for acute care services?

A: The issue of specialized needs of elders involves acute, chronic, and prevention needs. The acute care (acute general hospital) needs of Indian elders are currently being well met by both direct and contract health services. As the population of individuals over 65 years of age grows, increasing acute care capabilities will be required. It is currently within the capability of IHS to increase its inpatient load by 40-50% since inpatient facilities are not being fully utilized. In addition, IHS is refining its capability in ambulatory and community services directed at more effective outpatient and home-based acute, chronic, and prevention services. These services are not limited to addressing the needs of the elderly, but will provide necessary care.

Q: In IHS testimony, it was stated that services provided by IHS to those persons 65 years and older were more resource intensive than for younger patients. Additionally, if national trends in this population are extrapolated to the IHS service population, then the use of IHS acute services by the elderly will increase, resulting in an ever greater proportional use of IHS resources. What does this information mean in terms of improving the quality of care to Indian elderly? Does IHS feel that improvements could be made in the training of health professionals in geriatric medicine? If so, what types of educational programs should be included? Does IHS carry these out in a systematic manner?

A: As discussed in the previous question, there is available, unused acute care capacity and therefore the increased use of these services should not negatively effect the quality of care.

Improvements in training of health care providers are needed in the area of chronic disease management. Geriatrics is in large measure, an area of health interest that focuses on management of chronic diseases. Primary emphasis needs to be given to the elements of chronic disease management, then followed by specific elements of geriatric emphasis. Currently, training in these skills is managed on an area-by-area basis and includes a variety of course offerings purchased from medical shcools, nursing schools etc. Heretofore these courses have been focused on clinical skills. In FY 1987, the IHS will initiate a more comprehensive community analysis training plan to facilitate more effective needs identification, resource capability, and coordination skills in the use of resources. This will be similar to the CEC-sponsored P.A.C.H. (planned approach to community health) model.

Q: The IHS statement calls for development of "innovative home and community-based approaches to the chronic care needs of the elderly." What is IHS currently doing toward that end?

A: Several model programs are in existence (Zuni, Aberdeen, and Alaska Areas, etc.). These are designed around community based approaches to addressing elder-care issues. These models are being assessed for replication in other IHS settings.

Q: The IHS statement refers to an IHS Area that has established a Geriatric Health Coordinator position. What area is this? Please explain the program including cost. If New Mexico tribes wanted to establish such a position at the Albuquerque Area office, would this be possible? If so, what support would IHS provide and how could this be achieved?

A: The program is in the Aberdeen area. Plans were to advertise for physical gerontrologist for an 8 month appointment; however, there were no applicants. Subsequently, the Area advertised for a health professional to develop and coordinate a gerontology program. Mr. Bernie Long, an Indian physical therapist at Whiteriver, was selected. His arrival date is slated for November/December 1986 on the Pine Ridge Reservation. His duties would be one-half clinical and one-half area coordinator for geriatrics.

The area also had a physiatrist named Dr. Peter Markos, a scholarship obligated physician, based at Rosebud for August 1986. Duties were to provide primary care, and consultation to the geriatrics program as available.

If the New Mexico Tribes wanted to see such a position established in the Albuquerque Area Office, the procedure would be for them to make such a recommendation to the IHS Area Director. IHS would then make a determination as to the programmatic desirability and the financial feasibility of such a proposal.

Q: What would prevent IHS from establishing an Office of Gerontology Services? If money is the major obstacle, what would it cost IHS to establish such an office? What type of a program would IHS develop?

A: The IHS currently is of the belief that an office of gerontology services is not necessary. Enhancement of chronic disease management and community services will effectively address the needs of the aging population at least through FY 1990.

Q: Please explain the purpose of the "Indian Elders Initiative Task Group" sponsored by the Office of the Assistant Secretary for Human Development Services? What has this task group accomplished, published, or recommended regarding Indian elderly? Are the meetings open? Is there room for tribal input? When was the last meeting of this group? The next scheduled?

and

Q: Regarding the Indian Elders Initiative Task Group, is one of its purposes coordination of services to Indian elderly? If so, would it be an appropriate in-house function to work on an Indian policy statement?

A: The Indian Elders Initiative Task Group is currently inactive; it last met in 1984. It would not be the appropriate group to work on an Indian policy statement. Coordination of Indian issues is handled by the Intradepartmental Council on Indian Affairs. The Council is composed of the heads of all major components of the Department. Within the Administration on Aging coordination of Indian elders issues is handled personally by Michio Suzuki, Associate Commissioner for State and Tribal Programs.

Q: Last Congress during the reauthorization of the Older Americans Act, I included language both in the Senate and in the Conference Report directing AoA to establish an "Indian desk" that would involve the input of tribal seniors themselves. This never came about, and the statement AoA provided states that the Office of State and Tribal Programs is the "Indian desk."

To what extend does this office actually address Indian grantee concerns with AoA?

A:
- o The Administration on Aging, through its Office of State and Tribal Programs (OSTP), administers Title VI-- Grants to Indian Tribes. That Office makes the grants, provides technical assistance to Tribes and Tribal Organizations, and recommends further AoA initiatives and activities to the Commissioner based on continuing input from the Title VI grantees on their interests and concerns.

- o In each Federal region which has Title VI grants, there is a representative of the Commissioner who is a part of AoA's Office of State and Tribal Programs. This representative, the Regional Program Director, has frequent contact with the Tribes in the region.

- o AoA has also provided training and technical assistance to title VI grantees through contracts since 1980. These yearly contracts have provided one major training conference for grantees and one on-site technical assistance visit for nearly all grantees. The contract for fiscal year 1987 has been awarded to ACKO of Boulder, Colorado. This year it has been improved to increase the duration and quality of the training conference and to provide more days (270) of on-site assistance to Title VI grantees. OSTP is directly involved in the selection of the contractor and in monitoring the progress of the contract; it uses the information from the conference and visits in guiding the direction of the program.

Q: How does AoA justify that this office does outreach to Indian elders?

A: o OSTP provides outreach to Indian elders through its technical assistance to Tribes and Tribal Organizations which are Title VI grantees and through the training and technical assistance contract with ACKO, which underwrites one major training conference for grantees and one or more on-site technical assistance visits for nearly all grantees, particularly those with problems.

o AoA Regional Office staff are in regular phone communication with Tribes which are Title VI grantees and, travel funds allowing, they make on-site technical assistance visits which supplement those made under the ACKO contract. Additional travel funds have been requested for this fiscal year which would make more field trips to the Tribes possible.

In addition, some Regions have meetings with the Tribes in the regional Offices, making it possible for the Indians to communicate their interests, needs, and concerns to a broad spectrum of Federal managers.

Q: How does this office incorporate Indian Title VI grantee input?

A: o OSTP Central and Regional Office staffs are in regular phone communication with the grantees about their interests and problems, and personal meetings are held as needed or appropriate.

o The Commissioner on Aging has been holding leadership conferences to exchange views and suggestions on the future direction of the aging program with elements of the aging network. One of the recent meetings was with Indian leaders. Four AoA Regional Program Directors were in attendance and participated in the discussion from a regional perspective.

o Input is used in making grant decisions about use of both Title VI and Title IV funds. In addition, the FY 1987 Combined Discretionary Program announcement, the vehicle for soliciting applications for Title IV funding, has specific areas where Tribal Organizations are invited to apply.

o AoA's internal management tool has a FY 1987 initiative to enhance its responsibilities to Tribes and to work for greater cooperation between Title III (State and Community Programs) and Title VI.

The following are additional initiatives and/or activities which the Administration on Aging has undertaken on an agency-wide basis to demonstrate its commitment to the concerns of older Indians.

o AoA is working closely with the National Indian Council on Aging (NICoA). The Commissioner on Aging recently participated in the NICoA tenth annual meeting in Phoenix, Arizona, and more extensive dialogue with that organization has resulted. (A copy of Commissioner on Aging Carol Fisk's remarks at that conference is attached.)

o In FY 1986 AoA joined with the Administration for Native Americans (ANA) in funding a direct sales outlet for art work and crafts products of older Native Americans. The mechanism for sales has been a "crafts catalogue" produced under the grant. This "Buy Native American" project initiated a national public/private sector partnership between Phoenix Systems, Inc., a national for-profit marketing, training, and consulting company and NICoA.

o AoA has highlighted special opportunities for tribal grantees to respond to priorities under the FY 1987 Coordinated Discretionary Funds Program (CDP). (A copy of the recent Federal Register announcement on the availability of funds for FY 1987 is attached.)

o The Commissioner on Aging has recently been named to the Intradepartmental Council on Indian Affairs which meets to coordinate activities sponsored by the Department of Health and Human Services which relate to Indian interests and concerns.

Q: There are a number of Federal regulations and requirements which adversely affect the delivery of home health care services to Indian elders. For example, the criteria necessary to meet the Medicare "homebound" requirement do not take into consideration the unique cultural and physical environment of the Indian Elderly, e.g., religious and cultural activities; rural, isolated and often inaccessible living conditions; and seasonal living quarters.

a. What kind of changes in regulation or policy can be made to accommodate the unique circumstances of the Indian elderly?

b. Are there existing mechanisms, e.g., waivers, available that would allow for the different living circumstances of the Indian elderly?

c. How can Indian Tribes comment on current HCFA regulations?

d. Is there a liaison person who can respond to Indian elderly issues?

A: HCFA's discretion in implementing the law does not extend so far as to make policy or regulatory exceptions for specific categories of beneficiaries, if such exceptions are not specified by law; the Indians elderly are not so specified.

For Medicare beneficiares to receive covered home health services, the law requires physician certification that a patient is confined to his or her home. Administrative guidelines allow for some flexibility in interpreting this law, by indicating that a patient does not have to be bedridden to be considered confined to the home. For example, patients still may be considered homebound if the leave their home infrequently for periods of short duration as long as these trips do not demonstrate a capacity to obtain health care provided outside the home.

Similarly, the Medicare waiver of liability for home health services is confined to determinations of medical necessity. The waiver does not apply to nonmedical (technical) coverage determinations, such as the homebound requirement. However, Congress is considering a proposal in its current budget reconciliation package which would expand the waiver of liability to cover denials based on lack of houmebound status or because care was not intermittent.

Finally, Indian tribes may comment on current HCFA regulations by simply writing to HCFA's Administrator, William L. Roper, M.D. The concerns addressed in these letters (e.g., coverage or reimbursement policy) then would be delegated to the appropriate HCFA component, which would review and respond to the issues raised by the letters. While there is no one individual designated to handle Indian elderly issues specifically, persons wishing to raise such issues may do so by contacting either Dr. Ropér or the Regional Administrator responsible for Medicare operations in a specific State.

Q: What role does Medicaid play in providing home health Services to the Indian elderly?

A: Medicaid does not provide services, but finances home health services, through Federal and state payments for services, for individuals eligible for Medicaid.

The Indian Health Service (IHS) is just beginning to provide home health services directly and under contract. Those services provided directly by IHS to Indians eligible for Medicaid are reimbursed 100 percent from Federal funds. Services provided under and IHS contract are reimbursed using the standard Federal Medical Assistance Percentage.

Home health care is a mandatory service under Medicaid. States must provide home health services to categorically needy recipients over age 21 and to those under 21 if the State plan provides skilled nursing services for them. If a State plan includes the medically needy it must provide home health services to individuals entitled to skilled nursing services. Services provided must be on a physician's orders as part of a written plan of care. Home health services include three mandatory services (part-time nursing, home health aide, and medical supplies and equipment) and one optional service (physical therapy, occupational therapy, and speech pathology and audiology services). States may place limits on the number of visits or require prior authorization for the services.

Item 2

DEPARTMENT OF AGRICULTURE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20250

October 7, 1986

Honorable Jeff Bingaman
United States Senate
Washington, D.C. 20510

Dear Senator Bingaman:

Enclosed are responses to questions you submitted as follow-up to the hearing on "The Continuum of Health Care for Indian Elders".

If we can be of further assistance, please contact us.

Sincerely,

John W. Bode

JOHN W. BODE
Assistant Secretary
Food and Consumer Services

Enclosures

Question 1: Mr. Dickey mentioned that approximately 316,000 Indians participate in the Food Stamp Program and that approximately 15,000 of these are elderly. How many Indians participate in the Food Stamp Program in New Mexico? What percentage are elderly?

Response: Our information on participation of Indians and elderly Indians in the Food Stamp Program is based on a national sample. Sample sizes are not large enough to provide information on individual States such as New Mexico.

Question 2: USDA's testimony stated that the Food Distribution Program on Indian Reservations serves 81 Indian Tribal Organizations in five States for 194 Indian Reservations. Is New Mexico one of the five States that administers the program? If so, what specific Reservations are involved?

Response: New Mexico does indeed operate the Food Distribution Program on Indian Reservations. The Indian Tribal Organizations (ITO) and the reservations they serve are as follows:

ITO	RESERVATIONS
Acoma	Acoma and Laguna Pueblos
Eight Northern Indian Pueblos Council	Nambe Pueblo Tesuque Pueblo Picuris Pueblo Pojoaque Pueblo San Ildefonso Pueblo Santa Clara Pueblo San Juan Pueblo Taos Pueblo
Five Sandoval Indian Pueblos, Inc.	Cochiti Pueblo Zia Pueblo Jemes Pueblo Sandia Pueblo Santa Ana Pueblo
Zuni Pueblo	Zuni Pueblo

Question 3: Further, USDA's testimony stated that Indian household food preferences are taken into consideration in the completion of the food package. Can you tell me specifically how Indian food preferences are taken into consideration?

Response: Household food preference is considered in two ways. First, each Indian Tribal Organization keeps data on which items are preferred by individual households. The Tribe can then order and keep inventory on hand in accordance with what the Tribal members want. Second, we periodically review and revise the items that are offered to Tribes based on Tribal preference, availability, cost, nutrition, and other factors. For example, within the last year, Tribes reported to us that they wanted a canned luncheon meat to be added to the food package. After reviewing cost and nutritional data, this item was added and has proven to be very popular.

Item 3

ACTION
WASHINGTON, D.C. 20525

OFFICE OF
THE DIRECTOR

OCT 2 1986

Honorable Jeff Bingaman
United States Senate
Washington, D. C. 20510

Dear Senator Bingaman:

Pursuant to the field hearing in Sante Fe, at which Mr. Daniel F. Bonner, Associate Director, Domestic and Anti-Poverty Programs, represented ACTION, enclosed please find the additional questions you submitted for the record and my response.

Sincerely,

Donna M. Alvarado

Donna M. Alvarado

Enclosures

FOSTER GRANDPARENT PROGRAM • YOUNG VOLUNTEERS IN ACTION • SENIOR COMPANION PROGRAM
RETIRED SENIOR VOLUNTEER PROGRAM • OFFICE OF VOLUNTEER LIAISON • VOLUNTEER DRUG USE PREVENTION PROGRAM
VIETNAM VETERANS LEADERSHIP PROGRAM • VISTA • NATIONAL CENTER FOR SERVICE LEARNING

QUESTION

1. ACTION's testimony states that 57 VISTA volunteers are assigned to eleven Indian related projects. What percentage of the total VISTA volunteers does this figure represent? In particular, what specific projects are currently underway which use VISTA volunteers to meet the health and long-term care needs of Indian elders?

ANSWER

- 11 VISTA Projects
- 57 VISTA Volunteers Assigned
-.02 Percent of Total VISTA Volunteers
-.05 Percent of Projects

N.C. Commission on Indian Affairs 15 VISTAs
Raleigh, North Carolina

ACTIVITIES:

- Literacy, job readiness, increase participation in human services delivery system, and identify funding resources

S.C. Council on Native Americans 2 VISTAS
Columbia, South Caroline

ACTIVITIES:

- Literacy; strengthen management capacity of tribal council

Mille Lacs Band of Chippewa Indians 5 VISTAs
Onamia, Minnesota

ACTIVITIES:

- Home care for home-bound elderly; alcohol and substance abuse prevention, and youth recreation

Sault Ste. Marie Tribe of Chippewa Indians 3 VISTAs
Sault Ste. Marie, Michigan

ACTIVITIES:

- Substance abuse prevention; cultural awareness

Save the Children, Inc. 10 VISTAs
American Indian Nations Program
Albuquerque, New Mexico

ACTIVITIES:

- Community development; tutoring; recreation

South Dakota Urban Indian Health 7 VISTAs
Pierre, South Dakota

ACTIVITIES:

- Alcohol/Drug treatment and prevention services; single parent/family support groups

Small Tribes Organization of Western Washington 8 VISTAs
Sumner, Washington

ACTIVITIES:

- Alcohol prevention; youth recreation; elders meals program; crafts and business development; education programs

Fairbanks Native Association 5 VISTAs
Fairbanks, Alaska

ACTIVITIES:

- Tutoring; alternative elementary/secondary school

Klamath Indian Tribe 1 VISTA
Chiloquin, Oregon

ACTIVITIES:

- Develop tribal owned enterprise to market locally produced crafts

Abused Women's Aid in Crisis, Inc. No VISTAs
Anchorage, Alaska

ACTIVITIES:

- Abused elderly and Native Americans

Mental Health of the Metlakatla Indian Community 1 VISTA
Metlakatla, Alaska

ACTIVITIES:

- Alcohol abuse; family violence; child abuse; parenting skills; and, delinquency prevention

Question: Mr. Bonner testified that one of ACTION's major objectives is to assist communities to become self-sufficient. Yet, it is increasingly difficult to obtain local funding for maintaining services, much less to expand services to meet increased demand. Please describe ACTION-supported programs which have become self-sufficient, especially those benefiting Indian elders or providing long-term care services for the elderly. Have RSVP, Senior Companion or Foster Grandparent programs become self-sufficient?

Answer: Currently there are 23 Senior Companion Programs, with almost 1,000 Senior Companions, which are totally supported with non-ACTION funds. Two of these projects received ACTION demonstration funding for a three year period and continue with funding from state and local governments, foundations and the private sector. The remaining 21 were initiated and continued without ACTION funds. These projects range from 8 to 350 volunteers each. Although none of these projects is serving Indian Elders, all are providing long-term care for the elderly.

There are approximately 113 Native Americans who serve through 5 SCP projects. This represents 2 percent of the total number of SCP volunteers in the Program. The Companions provide in-home health services to other older Native Americans with chronic health conditions that limit their mobility. All work through tribal health authorities and comprehensive health care plans. There are about 240 in-home clients who benefit from Companion services.

Senior Companion Native American programs were first organized in 1978. Thirteen pueblos and urban Indians in Albuquerque receive Companion services. Nine volunteers are supported by funding from the New Mexico State Office on Aging. Assignments are coordinated through tribal health services aides and nurses. On the average, Companions serve 2.5 homebound clients per week. Often the results are dramatic. An elderly client wandered away from the Black Rock Elderly center on a Saturday. Forty-eight hours later, three Senior Companions discovered him at the bottom of a small cliff, a mile from the pueblo. He was taken to the pueblo's acute care hospital, treated for exposure and released. Hospital officials said the Companions saved the man's life.

Ten Foster Grandparent Programs are totally supported by non-ACTION resources. Two of these projects with 14 Foster Grandparents are located in Socorro and Truth or Consequences, New Mexico.

Six Retired Senior Volunteer Programs are non-ACTION funded. None of these projects serve the Indian population, but all provide some services to other older persons.

In addition to the Foster Grandparent Program, Senior Companion Program and Retired Senior Volunteer Program activities, The National Congress of American Indians (NCAI) and ACTION, the Federal Volunteer Agency, have started discussions to explore ways for expanding volunteer activities in Indian reservations. ACTION's experience gained in the administration of volunteer programs gives the agency a technical assistance capability that could be useful to Indian tribal governments interested in initiating or expanding volunteer activities within their jurisdictions.

The assistance that could be made available covers various aspects of program development and administration, including:

- developing volunteer assignments
- volunteer recruitment techniques
- budget formulation and management
- staff training, in conjunction with ACTION sponsored training conferences for project staff
- program materials, including technical assistance papers
- techniques for generating community support.

The Mille Lacs Band of Chippewa Indians in Onamia, Minnesota is a VISTA-supported program which is becoming self-sufficient. The five (5) VISTA Volunteers have increased attendance at recreation programs and have established a volunteer corps to assist elderly through home health care needs.

The volunteers are now directing their efforts toward expanding support systems for teenage drug abusers and alcoholics by establishing Alanon and Alateen groups on the reservation.

Item 4

THE SECRETARY OF THE INTERIOR
WASHINGTON

Honorable Jeff Bingaman
United States Senate
Washington, D.C. 20510

Dear Senator Bingaman:

Thank you for your letter of September 23, 1986, commenting on the Department's participation at "The Continuum of Health Care for Indian Elders" hearing held in Santa Fe, New Mexico.

For your information, I am providing the enclosed responses to the questions which you enclosed with your letter. We hope the responses will be of assistance in understanding the Bureau of Indian Affairs Social Services program for the elderly.

Please feel free to contact us if we can be of further assistance.

Sincerely,

Donald Paul Hodel

DONALD PAUL HODEL

Enclosures

1. QUESTION: How does the Bureau of Indian Affairs coordinate with other federal agencies in providing services to Indian elderly? Are there any inter-agency agreements established? Has there been any discussion of such agreements?

ANSWER: The Bureau of Indian Affairs (BIA) coordinates primarily with the Indian Health Service (IHS) and the Social Security Administration in the provision of services to Indian elderly. This coordination takes the form of meetings to exchange policy and regulation initiatives that potentially could affect Indian elderly. The BIA and IHS recently finalized a Memorandum of Agreement (MOA) which we feel will lead to a better service delivery system for Indian people of all ages. The MOA was the culmination of eight months of negotiation between the two agencies and is evidence of a new cooperative effort on behalf of Indian people. A copy of the MOA is attached for you information.

2. QUESTION: In terms of the BIA providing support for construction for nursing homes, what is the extent of BIA responsibility? Is it solely for construction, or is it for contracting out such services to off-reservation providers, or what?

ANSWER: The BIA has no authority or responsibility for the construction of nursing homes. The Bureau Social Services program does provide custodial care for adults which consist of non-medical care and protection to eligible clients when, due to age, infirmity, physical or mental impairment, those clients require care from others in his/her daily living. The custodial care is contracted out to both on-reservation and off-reservation providers.

3. QUESTION: Does the BIA have a policy to determine whether a nursing home will be built on the reservation or not?

ANSWER: The BIA does not have a policy which determines whether a nursing home will be built on the reservation or not.

MEMORANDUM OF AGREEMENT
BETWEEN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
DEPARTMENT OF INTERIOR
BUREAU OF INDIAN AFFAIRS

This Memorandum sets forth the terms of agreement for services to be shared by the Indian Health Service (IHS), the Department of Health and Human Services, and the Bureau of Indian Affairs (BIA).

I. Purpose and Scope

The purpose of this agreement between the IHS and the BIA is to foster a collaborative working relationship in youth Health Promotion and Disease Prevention (HP/DP) activities which are of common interest and shared responsibility.

II. Authority

Snyder Act (25 U.S.C. 13)

III. Substance of Agreement

Areas of Collaboration: The IHS and the BIA have identified major areas of common interest in HP/DP. Specifically the areas of focus are:

A. Youth alcohol and drug abuse
B. Nutrition
C. Curricula development for health promotion and disease prevention
D. Training for community health representatives (CHRs), health aides, tribal judges, law enforcement personnel, education and social service personnel
E. Teen-age suicide
F. Child abuse and neglect
G. Teen-age pregnancy
H. Fetal alcohol syndrome
I. Tobacco syndrome
J. Parent effectiveness
K. Special education
L. Special needs of elders
M. Injury control
N. Immunization for school age youth

IV. Responsibilities

The implementation of these responsibilities shall be developed in consultation with the Indian tribe(s) served by such programs by appropriate education and health personnel at the local level.

The IHS will provide a steering committee to ensure compliance with the responsibilities described in this agreement. The BIA representatives who will ensure compliance with the responsibilities described in this section are the Deputies to the Assistant Secretary for Education and Tribal Services.

A. The Indian Health Service agrees to:

1. Determine the extent of Indian youth health problems and the estimated financial and human costs of these problems.
2. Develop and provide comprehensive preventive Indian youth alcohol and drug abuse treatment services, including detoxification and counseling services, and aftercare concerns.
3. Provide immunization services to eligible school age youth who have access to IHS disease prevention services.
4. Assess the status of nutrition awareness training for CHRs, health aides, tribal judges, law enforcement personnel, education and social service personnel.
5. Assist in providing the awareness training for CHRs, health aides, tribal judges, law enforcement personnel, education and social service personnel.
6. Assist in developing curricula to address needs and objectives identified in the HP/DP program.
7. Utilize the maternal child health program which includes teen-age pregnancy, fetal alcohol syndrome (FAS), and child abuse to educate adolescents concerning birth control, problems of pregnancy, and child care.
8. Assist the IHS Service Unit Director into developing local action plans with the BIA and tribe(s) to address HP/DP needs of the community.
9. Review and implement a plan to provide clinical and mental health support services to BIA funded special education programs.

B. The Bureau of Indian Affairs agrees to:

1. Develop, coordinate and share materials designed to help special education teachers, regular program teachers, CHRs, and health aides to provide the best possible care of disruptive or potentially out-of-control youths. This information will be utilized in the areas of suicide prevention, alcoholism and drug abuse prevention, child abuse, health programs, special education, law enforcement, social services and the general health and welfare of Indian students.
2. Determine the extent of Indian youth social problems related to alcoholism/drug abuse and the estimated financial and human costs of these problems.
3. Identify school age youths in need of immunization services and refer them to the local IHS facility for services.
4. Assist IHS in developing and conducting training programs for CHRs, health aides, tribal judges, law enforcement, education and social service personnel in the areas of alcohol and drug abuse, crisis intervention and teen-age pregnancy and the causes and effects of FAS.
5. Require both the BIA agency and education superintendents to enter into local action plans with IHS Service Unit Directors to address HP/DP needs of the community.
6. Provide a program of instruction regarding alcohol and drug abuse prevention programs to students in kindergarten and grades 1 through 12.
7. Encourage parental and tribal participation in the development of educational programs and problem identification.

V. Period of Agreement

This Agreement shall continue in effect until IHS or BIA provides written notice of termination. Notice shall be given the other party at least (30) days in advance of the termination date.

VI. Modification/Provisions Amendment

This Agreement, or any of its specific provisions, may be revised by written approval of both parties signatory hereto, or their respective designees.

VII. Reports and Reviews

Periodic reviews of this Agreement shall be conducted by BIA and IHS.

Reports and action plans shall be submitted by field offices to BIA and IHS central offices. These reviews and reports will be shared with field offices.

VIII. Privacy Act Consultation

The confidentiality of information which identifies individual persons and is exchanged pursuant to this agreement between the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) is to be safeguarded in accordance with requirements contained in the Privacy Act of 1974 (P.L. 93-579). In addition, regulations of the Department of Health and Human Services (DHHS) which implement the Privacy Act of 1974 within the DHHS, contained at 45 CFR Part 5b, are to be followed.

Information exchanged between the IHS and the BIA which indicates a diagnosis, prognosis, referral or treatment of alcohol or drug abuse is to be protected in accordance with requirements contained in the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations issued by DHHS at 42 CFR Part 2.

IX. IHS/BIA Meetings

In order to assure that these collaborative efforts are pursued in a continuing and timely fashion, IHS and BIA representatives will meet on a regular basis, not less than semi-annually, to review the activities supported by this agreement and will share information, report on progress and explore new areas for collaboration. In addition, other meetings may be arranged to discuss specific projects.

X. Annual Summary

An annual progress report and summary of meetings and activities conducted under this agreement will be prepared by the respective contacts and submitted to the Agency Directors at completion of each fiscal year.

For: Indian Health Service
By: Everett R. Rhoades
Director, Indian Health Service

Date: SEP 1 2 1986

For: Bureau of Indian Affairs
By: Ross Swimmer
Assistant Secretary - Indian Affairs

Date: SEP 1 2 1986